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Recovering Political Knowledge in Public Health: Learning from Sexual and Reproductive Health Work

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Abstract

Like many areas of public health, sexual and reproductive health is concerned with politically contentious matters such as abortion and LGBT+ rights. Global setbacks at the hands of the far right highlight the extent to which the rights and practices underpinning sexual and reproductive health are politically mediated. Yet the political is often occluded in mainstream sexual and reproductive health responses. In this paper, I consider the recent travails of sexual and reproductive health in order to critique technocratic knowledge forms that dominate both sexual and reproductive health and public health responses. Exploring sexual and reproductive health responses across time and space, I identify alternative knowledge forms and approaches relevant to public health.

Background

Sexual and reproductive health (SRH) is concerned with politically contentious matters such as abortion, sexuality education and sexual and gender minority health. While researchers, practitioners and policy makers often attend to political contexts, evidentiary processes dominating mainstream SRH policy and programming tend to frame the political as troubling: for example, as unwelcome disruptions of the radical right. This framing reflects a tendency in public health to consider political knowledge forms as incompatible with evidence agendas elaborated within technocratic epistemological frameworks.

However, recent regressive policies are leading some to question why the political is often occluded in mainstream SRH responses. A recent special edition of *Sexual and Reproductive Health Matters* calls for “[...A]ctivists, practitioners, researchers, policy-makers and others engaged in promoting and protecting SRHR, to reflect on the various impacts that politics, in its various guises, continues to have in this field.” (Pugh, 2019):4. In this paper, I consider the role of political knowledge in public health through an analysis of SRH. Through a critique of technocratic knowledge regimes in public health, I discuss how over-reliance on such regimes is problematic. I then consider mobilisations of political knowledge in the form of structural and material critiques and argue that contemporary SRH challenges require a renewal of and re-engagement with political knowledge and a re-imagining of borders between ‘the political’ and ‘the techno-scientific’, an argument that has resonance for public health more generally.

As this commentary is based on my experience within the wider SRH field, it’s important to attempt to describe this. The field I discuss in this paper is made up of domestic and international

government funders, policymakers and programmers, non-governmental and community-based organisations, clinical practitioners, pharmaceutical industries, academic and other researchers as well as activists and advocates. The values predominating this field appear (to me) to be ideas of scientific rationalism, neo-liberal or market-based economic approaches and enlightenment ideals of individual freedom and responsibility. This is a stratified, agonistic field inhabited, more or less comfortably, by diverse actors including myself. Problematically, this field excludes particular worldviews by setting ontological and epistemological strictures on the forms of experience and knowledge admissible within it, and in so doing, will tend to perpetuate or present limited challenge to power asymmetries.

I hold relative power within this field as a white, educated man and senior academic. My role and engagement are mediated by my belonging to the LGBTQI community and my early involvement in HIV activism which made me aware of how public health and SRH knowledge production processes mediate power through medicalisation and pathologisation. This has shaped how I work as an applied SRH researcher inasmuch as I try to work alongside or as part of communities using participatory and co-productive approaches. My disciplinary formation is sociological, attending to social processes, structures and asymmetries and how knowledge production mediates these.

Critiques of contemporary technocratic knowledge regimes in public health

Public health has been subject to critical scrutiny regarding its move away from communitarian, collective and empowerment approaches in favour of technocratic and positivist epistemological processes (Sanders et al., 2008). This shift reflects broader trends in how knowledge is produced and deployed in what O'Regan and Gray (2018) have described as a 'bureaucratisation of knowledge production'. That is, intensive governance of public health knowledge production is aligning it with marketised logics and neo-liberal imperatives (Raphael, 2008). These logics ensures that knowledge demonstrating a measurable and immediate impact takes on greater value while knowledges with attenuated impacts are less valued. Thus, technical knowledge forms are pre-eminent across research, policy production and programming leading to hegemonic assumptions that the best public health interventions are those that are 'effective', 'replicable' and 'scalable' (Merz et al., 2021).

However, 'replicated' and 'scaled-up' interventions can flatten variation in terms of marginalization within and across communities, create effects invisible or illegible to programmers and lead to tensions between public health outcomes and social justice imperatives. Moreover, the ideal that evidentiary policy processes *should* be free of political content bespeaks the assumption that scientific method and process are *already* epistemologically 'pure'. This assumption is questioned by science and technology and critical policy studies scholars (Cairney, 2016; Gorur et al., 2019) who highlight implicit political imperatives at play in technocratic evidentiary policy-making processes. Others argue that technocratic lenses render cultural and political factors invisible in policy processes characterising technocratic processes of knowledge and policy production as intrinsically, but only implicitly political (Harrison, 1998) (Rodwin, 2001). Critics of these tendencies in public health have argued that far from being politically neutral, such deployments of technical knowledge forms amount to a form of epistemic violence (Dotson, 2011) that normalises and perpetuates racial-capitalist forms of knowledge production that in turn, ensure the reproduction of racialised health inequalities (Petteway, 2023). Others argue that the predominance of certain forms of

evidence within public health policy render key groups and health needs invisible and support non-action and non-accountability around these needs as norms in global public health (Lee, 2023).

In evacuating social challenges (such as those associated with public health) of their political meaning, technocratic knowledge regimes limit the range of possible responses, replacing agonistic political responses to health challenges with neutral, value-free technical 'solutions' (Brown, 2015). These technical forms of governance not only relieve decision-makers of political accountability but alienate people from democratic processes of decision-making, devaluing their political beliefs and undermining critical political thought, action and literacy (Brown, 2015; Harney & Moten, 2013).

SRH's evidence processes - how research is produced, translated into evidence and inserted into policies and interventions – are closely aligned with public health. Technocratic knowledge forms in SRH have been similarly critiqued as re-framing neo-colonialist and proto-eugenicist impulses as neutral, technical and inevitable, particularly in the area of global reproductive control (Bendix & Schultz, 2018). Others highlight how technical and economic renderings of LGBT and women's SRH rights (that rights-granting countries reap economic dividends) de-fang the agendas they purport to defend, detaching them from critiques of structural and material inequality redeploing them as 'soft' interventions to render populations amenable to securitizing, neoliberal agendas (Badgett et al., 2014; Puar, 2007).

While recognising these critiques, the purpose of this paper is not to reject technocratic knowledge regimes in public health *tout court*, but rather to consider how such regimes fail to provide the epistemological heft that public health actors need to deal with contemporary challenges. I do this by discussing recent developments in SRH, considering what forms of knowledge actors need to defend SRH rights, and suggesting ways of working across different knowledge forms. Insights gained from this consideration will have broader resonances for public health.

A closer look at knowledge production in SRH: U=U

Looking closer at SRH knowledge production, we discern clear epistemological and methodological segmentations. Experimental approaches, such as randomised control trials have emerged as the 'gold standard' of evidence production. Approaches that examine the complexity of interpersonal and social life (qualitative or ethnographic approaches) are generally assigned the role of generating contextual knowledge to inform intervention development. Other social scientific approaches are employed to demonstrate social determinants of differential health outcomes, to explore in-depth experiences of ill health or to explain how social and cultural factors exacerbate health inequalities. Such knowledges are often mobilised in collaboration with community or civil society organisations to facilitate education or awareness-raising necessary for changing behaviours or adopting new biomedical technologies.

There are many examples where this knowledge ecology has led to transformative SRH programmes. For example, the repurposing of HIV pharmaceutical treatments for HIV prevention have led to the development of population HIV prevention programmes based around Treatment as Prevention (TasP) and Pre-Exposure Prophylaxes (PrEP). The efficacy of TasP and PrEP has been demonstrated in population trials with much qualitative research into their acceptability (Bavinton et al., 2018; Cohen et al., 2011; Rodger et al., 2019). These programmes entailed massive community mobilisations in the form of a global U=U campaign (Prevention Access Campaign, 2022). U=U stands

for Undetectable = Untransmittable. When a person with HIV and is on effective treatment, it lowers the level of HIV (the viral load) in the blood. When the levels are extremely low it is referred to as an undetectable viral load or 'virally suppressed'. At this stage, HIV cannot be passed on sexually. Undeniably, U=U is an example where technocratic, biomedically inflected knowledge forms work well alongside social and communitarian knowledge forms.

However, when bio-epidemiological/behavioural/communitarian interventions such as U=U yield shortfalls in predicted outcomes, qualitative research, generally undertaken under the rubric of 'programme knowledge' and 'process evaluation' seek to identify factors that inhibit programme effectiveness and sustainability. This research often highlights factors such as stock-outs and system failures associated with conflict, environmental disaster, corruption, and lack of resources. They might also identify cultural or social factors such as stigma and discrimination or criminalisation of key populations. Most importantly, social inequality and poverty are also recognised as confounders.

However, within technical knowledge regimes, factors such as conflict, environmental disaster, corruption, discrimination and stigma often become the subject of misrecognitions. On one hand, they register as intractable because they are not amenable to *technical* responses. Another, very different tendency is to construct them *solely* as a technical problem. An example of this are framings of HIV stigma. Stigma is a foundational social process and a perpetuator of deep inequality which is treated in this framing as a pathogen to be measured, surveilled and eventually eradicated by the right anti-stigma campaign (Friedland et al., 2020).

Technocratic and programmatic knowledge regimes also tend to construct poverty and structural inequality as significant *only because* they drive specific morbidities or limit programme effectiveness rather than seeing them as issues that go to the heart of social justice and political economies. So, climate disaster, conflict and extremism (religious, cultural or fiscal) may limit the effectiveness of bio-social HIV prevention but they also displace entire populations with huge health detriment and appalling rights abuses. Technocratic knowledge regimes cannot engage effectively with problems such as poverty, conflict, climate disaster, inequality, stigma and discrimination because these are not technical problems to be 'solved' or 'eradicated' but are ongoing, enduring *political* challenges that require ongoing political engagements, radical social movements or incremental transformations in the ways that societies organise themselves.

The limitations of technocratic approaches are also apparent in the arena of SRH 'rights work'. Those charged with developing capacity around sexual and reproductive rights will be aware of tensions and contradictions engendered by operating within technocratic knowledge regimes. An example would be attempts to design and evaluate scalable, replicable interventions to improve rights whilst steering clear of the geo-political realities that underpin inequality and injustice. A related example would be developing community-based or 'bottom-up' interventions which entail attempts to translate antagonistic, context-dependent and tactical community-based actions into technical, 'value-free' approaches for global funders. These limitations are evident in critiques of public health and SRH rights-based approaches (Campbell & Nair, 2014; Murray et al., 2021). However, this situation suggests a rather schizoid position for those working in health rights: work within the technocratic space whilst not speaking of the political and/or critique the technocratic space from a political position without. This bifurcation maintains a border between the technological and the political with the political kept outside mainstream SRH responses.

So, although mobilisations such as U=U are remarkable and essential, it is questionable whether they are *political*. This is because they generally don't articulate a critique of, or challenge to, structural inequality (or if they do, inequality is significant only inasmuch as it confounds the intervention). Indeed, there have been compelling empirical analysis of social mobilisations around these biomedical technologies that, while recognising their value, question their capacity to respond to salient broader political imperatives (Martinez-Lacabe, 2021; O'Byrne et al., 2021). This is not to say that actors don't act politically around these interventions. While interventions like 'U=U' compel grassroots activists to align themselves with global technical regimes to access funds mainly controlled by 'western' actors, many work politically through these arguably neo-colonialist programmes by, in turn, re-aligning the technical aims of global programmes with local imperatives around inequality or by leveraging their own status as public health actors to make social justice demands of local bodies (Lakkimsetti, 2014). Notwithstanding these welcome political redeployments, the question of whether programmes are political is not just a definitional one but goes to the heart of why many public health and SRH programmes are less sustainable and less effective than they could be.

Moving away from technocratic knowledge

Global events are calling public health's reliance on technocratic knowledge regimes into question. The links between inequality and health outcomes are well established. However, the COVID pandemic has illustrated painfully the extent to which such inequalities remain entrenched, how they underpin how societies arrange themselves and most soberingly, who lives and dies of COVID (Suleman et al., 2021). Technical knowledge forms alone are of limited use when we are thrown back upon what we have known for decades: proving 'scientifically' that social and economic inequality are correlated to health inequality does not translate into action to remediate it. Although there are calls for societies to learn from the lessons of the pandemic, to reform how we live and work and recognise and act on global interdependencies (Green et al., 2022), it remains to be seen how much these calls will be heeded.

In the SRH arena, the far right's interpellation of foundational political principles such as bodily autonomy, gender and race equality and the rights of minorities to self-determination are precipitating crises which also reveal the limitations of technocratic knowledge forms. There has long been compelling evidence for the safety of abortion over childbirth and how limiting abortion access leads to adverse health and social outcomes, especially for marginalised groups. This evidence has not deterred the imposition of abortion bans across the world through successive global gags (Singh & Karim, 2017), the creation of abortion deserts across the United States (Cartwright et al., 2018) and the overturning of *Row versus Wade*.

Likewise, empirical evidence on health disparities and morbidities and the benefits of clinical interventions for trans and non-binary people's rights are of limited use when faced with 'culture war' debates in the UK, USA and other parts of the world. The sequestering of trans experience by right wing political discourses detract from consideration of arguably more important political questions that profoundly affect the health of trans communities, such as the right to appropriate health care and the right to legally self-identify independent of clinical diagnosis.

It is increasingly clear that citing 'the evidence' is insufficient to counter geo-political forces, social divisions and structural inequalities that underpin SRH challenges. So, what kinds of knowledge are needed?

Political SRH Responses

In addition to technical and biomedically-inflected knowledge forms, we need to foster knowledge forms and sensibilities that are political, embodied, affective and communitarian in nature. There are signal instances of SRHR advances that demonstrate these knowledge forms.

At a time when reproductive justice is in retrenchment across the globe, Ireland secured abortion rights in the south in 2018 and the north in 2019. Although there were important differences between the campaigns north and south, both mobilised alliances of actors including abortion activists, minority communities, journalists, politicians, clinicians, community leaders, artists, cultural figures, students, trades unions and professional bodies. They were inscribed within politically and culturally valent arenas (for example, church and state relations in the south, histories of sectarianism and imperialism in the north) and based solidly within feminist political frameworks. Testimonial and embodied collective protest and arts-based practices were central to establishing abortion as a medical and social norm and changing orthodoxy around reproduction (Duffy, 2020; O'Shaughnessy, 2022; Rossiter, 2009). These approaches placed reproductive justice within the politics of health. That is, ill health and disease are not only a biomedical challenge but are symptomatic of and only ultimately resolvable by structural and political change. Moreover, they required collective knowledge mobilisation and understandings in addition to individual or institutional knowledge processes and involved people and groups going through transformative, often pedagogical encounters. Finally, they emerge out of and speak to political tension affording diverse and potentially contradicting responses (Bloomer & Campbell, 2022).

The Irish abortion campaigns reflect earlier political SRH approaches. LGBT rights were achieved in part through collective action based on embodied and affective experience of connections between heteronormativity and material inequality (Nguyen, 2021). Essential also were the deployment of anti-medicalisation discursive knowledge which challenged oppressive medico-legal orthodoxies (Conrad & Schneider, 1992). These anti-medicalisation approaches have re-emerged in contemporary trans rights work (Cannoot, 2019; Castro-Peraza et al., 2019). Novel knowledges were created through experiments in how people arranged their intimate and social lives as well as through testimony (Plummer, 1995). Thus, epistemic practices and deployments played an important part in social transformations. Likewise, early HIV activists visually represented the links between HIV, structural and gender inequality (Patton, 1990; Watney & Carter, 1989) creating new forms of knowledge and new framings of the virus which resisted either its reduction to a biomedical pathogen or as a moral judgement on those living with HIV. These responses mobilised embodied, affective and enacted knowledge forms (Gould, 2009; Keogh & Dodds, 2021).

These approaches do not claim universal, value-free, or neutral epistemic principles applied unproblematically to any setting, locality, population, or community (Barry, 2006; Latour, 1999). Nor do they seek to generate promissory and future-oriented universalizable principles or approaches (Ong, 2007). In short, there are no complex programmes or interventions to get abortion legalised, win LGBT rights, invent safer sex, or create communities of care. Rather they depend on democratic process and political strategizing based on embodied and affective experiences of links between

sexual and reproductive justice and foundational political concepts such as gender, race and class inequality, colonialism, imperialism as well as overarching geo-political crises such as climate emergency.

Conclusion: Creative tensions in public health?

Insights gained from politically inflected responses to SRH challenges have resonances for public health more broadly. Prioritising political knowledge forms in public health programming offers the potential to temper the universalising claims of technocratic knowledge regimes while generating useful knowledges that engage with complex challenges. This will require changes to public health knowledge production processes involving creative tension, agonistic encounter and contradiction. To conclude, I will consider possible 'creative tensions' under three headings: knowledges, actors, and spaces.

Knowledges

How can the public health knowledge ecology be re-balanced away from technocratic epistemologies? First, it may be possible to generate conditions for people and groups to think critically around their embodied and affective experiences and responses. This is not about doing qualitative research (valuable though that is) but communities engaging in critical dialogue enabling them to generate evidence, policy, learning and practice. There are helpful examples of this in the Irish experience (Bloomer & Campbell, 2022). This might be accompanied by changes in how public health is taught, perhaps considering how co-production of learning could be fostered, particularly through anticolonial pedagogic approaches that attend to how and where teaching occurs, which knowledge systems are at play and the potential for educator and educated to engage in mutually transformative pedagogic encounters (Sefa Dei, 2008).

Insights from decolonising, feminist, queer, critical race studies and critical legal studies disciplines are essential as they describe the ways in which ontological and epistemological paradigms render key knowledges and viewpoints illegible (Chalmers, 2017; Kuokkanen, 2000; McCarl Nielsen, 2020; Nash & Browne, 2010). Thus, it is not simply a question of different people and communities creating knowledge but also about transforming current paradigms (Mutekwe, 2015; Odora-Hoppers, 2002), bringing different sensibilities, commitments, imperatives and methodologies to knowledge creation (Bangura, 2011; Nash & Browne, 2010; Vivetha & Kinsella, 2021). These disciplines can also serve to contextualise the ontological and epistemological claims of technocratic rationalities: claims to universal principles that remain valid regardless of spatial and temporal specificities, which assume an immutable, valid set of 'scientific' principles that can be applied to any situation or context. In contrast, political knowledges from these disciplines are multi-valent, context and time specific and lend themselves to responses that draw and hold together multiple, more or less complementary, perspectives and imperatives. These responses are not 'permanent solutions' but fleeting and fleet-footed responses to specific challenges. They are not 'scalable' nor 'transferable', but there is much to be learnt from sharing practices and principles derived from them.

Actors

The imperative to engage in participatory ways with excluded or marginalised communities in public health work has long been established with many examples of good practice. However, it is also vital

to attend critically to the ways in which certain actors working at the grassroots or in politically contentious ways are excluded from global and local public health programming. Once again, insights from analyses of global SRH programming are instructive. Leaving aside violent suppression, 'softer' ways of excluding actors include the deployment of 'neutral' administrative procedures. For example, global SRH funders' due diligence checks often preclude grassroots organisations from participating in international SRH partnerships (Keogh & Olaniyan, 2022). Likewise, governments use administrative law to deprive community-based organisations of NGO status rendering them ineligible for international funding (France Médias Monde, 2019). These gatekeeping procedures serve to exclude actors critical of national and global governance— precisely the perspectives needed in public health programming. Key explanatory concepts such as epistemic justice (Fricker, 2007), epistemic injustice (Bhakuni & Abimbola, 2021) and epistemic violence (Dotson, 2011) may support changes in how actors engage with each other. That is, understanding how unjust epistemic practices and social inequalities are mutually reinforcing; of how actors are permitted to speak (or not) and are spoken to in specific arenas as well as notions of actors' credibility as epistemic agents. Reframing recent crises in public health in terms of epistemic justice will help formulate more robust responses (Matthews et al., 2022).

Spaces

To benefit from multi-directional transformative encounters, institutions involved in generating and implementing public health programmes need to critically consider the epistemic spaces they create and who inhabits them. Such institutions include universities (involved in research, teaching and 'knowledge exchange'), government (involved in enacting policy, commissioning and regulating services), civil society institutions such as community-based service providers, policy/ lobbying organisations (involved in policy development and service provision), grassroots organisations (involved in activism and advocacy), the judiciary (involved in regulating and policing health-related behaviours and commodities) and the private sector (involved in the manufacture of biomedical health commodities and service provision).

It is essential to consider what these spaces physically are (for example, academic or professional publications, social media, clinical spaces, spaces of community encounter), how they are constituted and regulated and the different resources actors draw on to be heard within them (Renedo & Marston, 2015) in order to recreate them as sites of critical encounter, debate and exchange open to all those with a stake in public health (Cornwall & Coelho, 2007). Spaces are needed that allow people to speak across and to epistemological, ontological and political difference and engage fully in the productive tensions these differences entail. These spaces would have the potential to facilitate the creation, curation and transformation of critical cross-disciplinary and useful knowledge to respond to public health challenges as they emerge. Thus, public health knowledge production could embrace a multiplicity of epistemological and ontological positions working across rather than within disciplinary silos.

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