

Practice.

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Abstract booklet

ECSM25

1st European Conference on Social Medicine



**UNIVERSITY
OF OSLO**



HGSM
Hub for Global
Social Medicine
Barcelona

Final version - 25th of June 2025

Conference program

Friday June 20th - Pre-conference

15.00-17.00	Field visits City tour by a drug user activist (Gatestemmer) or visit to the Healthcare Center for Undocumented migrants. Separate registration.
17.00-19.00	Dinner (self-organized) at Vippa (Akershusstranda 25)
19.00-22.00	Workshop: An Evening of Action A handful of interactive mini-workshops. Separate registration. at Melahuset

Saturday June 21st

08.00-09.00	Check-in and registration at Eilert Sundts house (Moltke Moes vei 31)
09.00-09.30	Welcome and Introductory Remarks: Background & vision for the conference + Organisational announcements
09.30-10.30	Plenary keynote By Helena Bjerring Hansen MD, PhD Professor and Interim Chair of Psychiatry and Biobehavioral Sciences at UCLA's David Geffen School of Medicine
10.30-10.45	Break/move
10.45-12.15	<u>Concurrent research presentations, sessions 1A-1E</u> 1A: Turn towards politics 1B: Conceptualizing health inequity 1C: "Learning Social Medicine – Medical students' perspectives from Germany" 1D: Mental health/care 1E: Antibiotics as global objects: The paradoxes of access and excess
12.15-12.45	Lunch
12.45-13.45	Poster and "Creating & Engaging" Session

13.45-14.45	Plenary keynote By Ghassan Abu-Sittah, MD Professor of Conflict Medicine at the American University of Beirut
14.45-15.00	Break/move
15.00-16.30	<u>Concurrent research presentations, sessions 2A-2E</u> 2A: The system is working as intended – critical perspectives on global health and complexity in colonial violence 2B: Medical knowledge/s meet 2C: The Case Series in Global Social Medicine: an inter-disciplinary toolkit: 2D: Care outside of healthcare 2E: The Practice and Praxis of Structural Ableism in Healthcare
16.30-16.45	Break/move
16.45-17.30	Plenary session: Building social medicine networks in challenging times
19.00	Dinner and social activities at Cafetheateret (Hollendergata 8)
Sunday June 22nd	
09.00-10.00	Plenary keynote By Ketil Slagstad MD, PhD Fellow, Institute for History of Medicine and Ethics in Medicine at Charité, Berlin
10.00-10.30	Break/move
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Plenary sessions

Saturday 9.30-10:30

BioSocial Futures: Toward a Community Ecology of Health and Well-Being

Helena Bjerring Hansen MD, PhD

Departments of Psychiatry and Anthropology, University of California Los Angeles, USA

Commentator: Suban Yusuf Mohamood MD, MPH

This talk is based on over a decade of participant observation in the field of Translational Social Science and the use of social technologies in relation to health inequalities. It provides a case study in the author's research on race and the development and marketing of new opioids that led to the contemporary opioid crisis. The study of opioids revealed "technologies of whiteness" - neuroscience, new biotechnology development, regulation and marketing - that explain the racial symbolism and demographics of opioid use. The talk ends by interrogating the magic bullet ideology underlying the persistent lack of investment in social and structural determinants of health equity, including the biomedicalization of addiction in the era of white opioids, while offering approaches – from “structural competency” to BioSocial research and community ecological medicine – to addressing the institutional and policy drivers of the overdose crisis.

Saturday 13.45-14.45

Liberation Medicine and the cure from humanitarian charity

Prof. Ghassan Abu-Sittah MBChB FRCS(Plast) DHL (hc)

Professor of Conflict Medicine at the American University of Beirut, Lebanon

Commentator: Sara Soraya Eriksen MD

The year 2024 ended with the iconic photograph of Dr Hussam Abu-Safiyeh walking in his white coat amidst the rubble of Jabalya camp towards an Israeli tank. In this lecture I chart the evolution of the role the medical profession played in anticolonial and anti-imperialist struggles. From Che Guevara's famous "Revolutionary Doctor" speech through the work of Franz Fanon in the Algerian liberation struggle and the role that the provision of healthcare played in the Palestinian liberation struggle from the 1960s to the first and second Intifadas and onto this genocidal war. I will try to show how Humanitarian medicine constituted an abandonment of the ideals of

Liberation Medicine and became a tool of imperialist soft-power. I will explore the central role Liberation Medicine has played in Palestinian resistance to genocidal necropolitics during the Gaza Genocide and the implications for Liberation Medicine as an idea.

Sunday 09.00-10.00

Trans History and the Problematic Legacy of Social Medicine

Ketil Slagstad MD, PhD

Fellow, Institute for History of Medicine and Ethics in Medicine at Charité, Berlin, Germany

Commentator: Emma Lengle MD, MPH

The specter of a “trans epidemic” is haunting the world. In response to the increased visibility of transgender and gender-nonconforming people and their demands for recognition, politicians, activists, researchers, and health professionals have mobilized the language of epidemics and the metaphor of social contagion to restrict rights for transgender people and access to medical transition. In these discussions, social media is often portrayed as a “vehicle of transmission” of trans identity. However, as this keynote will argue, this argument has followed transgender medicine from the beginning. Taking a politicized and controversial contemporary issue as its starting point, this keynote asks what we can learn from history for political and medical discussions today. It argues that since the emergence of transgender medicine in 1920s Europe, a major goal of physicians and the state has been to restrict access to medical treatment to shape and change sex – or what today is referred to as gender-affirming treatment. By highlighting the conflicting roles of medicine and state bureaucracy in the regulation of sex and the protection of the sex binary, we gain a deeper understanding of the normative underpinnings of social medicine. To understand this history, but also the attempts of subcultures and activists to influence stakeholders and shape medical practices, we need to focus on the role of the media. In other words, the history of transgender medicine is a history of mediatization. This keynote will present various forms of media – images, film, pamphlets, newspapers, and magazines – to analyze both repressive and emancipatory approaches to trans and gender-diverse communities throughout the twentieth century. It concludes that historical awareness of the normative underpinnings of social medicine can foster a more socially inclusive, epistemically just, and politically aware clinical and scientific practice toward sexual and gender minorities.

Panels

1 - Saturday 10.45-12.15

1A: Turn toward politics

Chair: Jeremy Greene, Johns Hopkins University, USA

Luke Messac - The Sacred and the Profane: The Hospital Corporation of America and the History of Profit in Medicine

Manar Al-Khodari - Bridging Medical Practice and Social Realities: A Case Study of Palestinian Medical Students in Crisis

The Sacred and the Profane: The Hospital Corporation of America and the History of Profit in Medicine

Luke Messac, Harvard Medical School, USA

Is medicine any different, really? In an age when the profit motive has become everywhere dominant, when wealth has become the unquestioned barometer of success, is medicine governed by different values and motives? During my research on the history of the medical debt collection industry, these questions arose again and again. Nonprofit hospitals were born of alms-houses and religious orders, yet today they hire debt collectors to file lawsuits against impoverished patients. Physicians were once independent professionals, yet today most work for large corporate entities, including private equity firms and insurance companies. Drawing on Emile Durkheim's notions of the sacred and the profane, this paper explores the social, political, and intellectual histories of profit in medicine through the rise of the Hospital Corporation of America (HCA). This history is based on archival research, corporate disclosures, investor calls, and investigations by journalists and public prosecutors. Founded in 1968, this for-profit hospital chain grew to become one of the largest companies in the United States. Its founders and executives, who were also magnates in fast food chains and for-profit prisons, demanded the cost cuts and rapid growth valued by capital markets. The firm seemed impervious to scandal; it paid a large fine after being found to have defrauded public insurers, but the chief executive at the time is now an influential US senator. The history of HCA demonstrates the subsumption of medicine into dominant logics of capital, and the erasure of boundaries between the sacred and the profane.

Bridging Medical Practice and Social Realities: A Case Study of Palestinian Medical Students in Crisis

Manar Al-Khodari, Al Azhar University Medical School, Egypt

The intersection of medicine and social sciences is vital in understanding how conflict, displacement, and structural inequalities shape healthcare delivery and medical education. This paper explores the experiences of Palestinian medical students who have had their education disrupted due to war, displacement, and systemic barriers, using a combination of qualitative case studies and personal experience.

Through an interdisciplinary lens, I highlight how medical students navigate these challenges by integrating social medicine principles into their learning and clinical practice. This includes grassroots educational initiatives, adapting to resource limited healthcare settings, and fostering resilience through global academic exchanges. The study also reflects on my personal journey of continuing medical education across multiple countries, comparing healthcare access and training in Oslo, Pretoria, and Gaza.

By bridging perspectives from medicine, public health, and social sciences, I argue that education and international collaboration are key to mitigating the long-term effects of conflict on healthcare systems. The paper concludes with recommendations for integrating social medicine frameworks into medical curricula to better equip future healthcare providers in addressing social determinants of health, particularly in crisis settings.

This work contributes to ongoing discussions on solidarity driven health education, trauma-informed medical training, and the role of interdisciplinary approaches in shaping the next generation of socially engaged physicians.

1B: Conceptualizing health inequity

Chair: David Jones, Harvard University, USA

Naoimh McMahon - Using visual metaphors to explore the role of dominant intellectual frameworks in constraining action on inequalities and points of entry for change

David Healy - Exploring how health inequalities are conceptualised and measured in patient experience surveys in acute care: a protocol for a scoping review

Emma Lengle - The desire for being otherwise: Futures of urban health (in)equity and the City of Oslo's utopian impulse

Bram Wispelwey - Causality by other means: Contending approaches to theorize the settler colonial determination of health

Using visual metaphors to explore the role of dominant intellectual frameworks in constraining action on inequalities and points of entry for change

Naomih McMahon, Lancaster University, UK

Despite significant attention to the issue of health inequalities in England, improvements have been slow to follow. Critical scholars, who have interrogated this gap between rhetoric and action, have illustrated how dominant intellectual frameworks permeate the work of policy and practice institutions in ways that constrain both thinking and action on health inequalities. In particular, they highlight how the issue invariably comes to be framed as a problem of individuals rather than as the inevitable outcome of deeply inequitable social and economic arrangements. The consequence of this framing is a proliferation of policy responses limited to servicing the symptoms of inequality, while leaving intact the social conditions sustaining inequality. The aim of this research was: (i) to convert these insights from critical scholarship on the dominant mode of problematising inequalities (and potential alternatives) into illustrated visual metaphors, and (ii) to explore the value and practical utility of these illustrations with a diverse range of actors working to influence institutional responses to inequalities. In this talk, I will present findings from this ongoing qualitative research on the extent to which the visual metaphors were perceived by actors to offer a constructive resource for collectively interrogating contemporary constraints on thinking and action, and points of entry to realise transformative social change.

Exploring how health inequalities are conceptualised and measured in patient experience surveys in acute care: a protocol for a scoping review

David Healy, University of Galway, Ireland

Background: A comprehensive examination of whether and how health inequalities are measured in patient experience surveys has yet to be completed. The various ways in which these surveys conceptualise health inequalities may have important implications for how information about inequalities in patient experience is reported and used to plan quality improvement in health services. This review aimed to map measured and overlooked health inequalities in patient experience surveys in acute

care and to explore the potential consequences of different conceptualisations of these health inequalities.

Methods: Papers that contain materials relating to patient experience measurement in any acute care context were included. A search strategy was developed. Grey literature searches were completed in collaboration with relevant experts. Two independent reviewers completed title and abstract, and full-text screening. The extracted data will be analysed using Critical Discourse Analysis, a qualitative method used to examine how power, dominance and inequality are enacted in text.

Results: 141 studies were included for data extraction. To-date, data from 91 studies have been extracted. Notable findings include, 66% of studies were conducted in the USA, in 90-97% of studies measurement of disability status, social capital, socioeconomic status, or occupation in patient groups was not reported, with measurement of sexuality not reported in patient groups in any studies. A critical discourse analysis of included studies is underway.

Implications: This review will provide stakeholders involved in designing, implementing and responding to patient experience surveys with further insights into how health inequalities may be currently overlooked in these surveys.

The desire for being otherwise: Futures of urban health (in)equity and the City of Oslo's utopian impulse

Emma Lengle, University of Oslo, Norway, and Harvard Medical School, USA

What might we better understand about urban public health policymaking and health (in)equity by way of an interest in health utopias? The City of Oslo's public health strategy on social inequality in health does not identify a specific target group upon or within which to elevate health outcomes, but rather depicts glimpses of a future of urban flourishing. The City's vision does not go quite as far as totalizing health equity, yet it certainly depicts an Oslo where any group-based variation in health outcomes is less significant than individual- or city-level variation. The effects of crafting the strategy in this way are manifold. First, socially constructed group-based inequities in the distribution of health outcomes in the city, which are well established in contemporary population health statistics, are invisibilized and stabilized. Second, visions of health equity are legitimized as reasonable goals to strive for. When believed to (eventually) be within reach, policymakers and politicians act in ways that do, materially and epistemically, put equity within reach. I argue that this policy move, and its embodied impacts, might best be understood as prefigurative (Levitas, Olin Wright, Cooper) and read within the Nordic tradition of

welfare universalism (Vike). Simply put, the bureaucrats of the City's public health strategy enact – bring into being through action – universalist welfare futures. As such, I reformulate the Norwegian policy inclination towards a welfare universal as a utopian impulse in the bureaucrafting of the current and future health (in)equity.

Causality by other means: Contending approaches to theorize the settler colonial determination of health

Bram Wispelwey, Harvard T.H. Chan School of Public Health, USA

Indigenous communities have long observed that settler colonialism radically reconfigures their lifeways, driving adverse social conditions and health outcomes. In shaping societal structures and processes of racialization that propagate health inequities, settler colonialism has been conceptualized to causally impact health through a dynamic, multifaceted process. Traditional methodologies in the health sciences that default to linear causal assumptions, however, are incapable of representing, mathematically or otherwise, the experiential and hypothesized complexity of the phenomenon. Defaulting to certain beliefs about causal influence, based largely on historical precedent rather than the theorized fundamental nature of the phenomenon, creates the conditions for epistemic exclusion, whereby the insights from Indigenous epistemologies and settler colonial studies cannot be represented and thus are not observable using standard health sciences methods (e.g. frequentist statistics, directed acyclic graphs, epidemiological surveying methods, etc.). In generating parallel, isolated knowledge systems, epistemic exclusion removes the possibility of synergistic progress and reduces the trustworthiness of any consensus that emerges from scientific discourse. By lacking diversity in hypotheses and methods explored, such a consensus would fail to reflect the complex nature of the phenomenon of interest. To practically address the incompatibility between the limits of traditional methodologies and the inherent complexity of the settler colonialism hypothesis, we propose a path to formal modelling that follows the theory construction methodology. Drawing from several settler colonial contexts, we briefly consider contender approaches that might be utilized to develop and transform abduction-derived prototheories into formal models, including dynamical systems modelling, agent-based modelling, and INUS condition logic.

1C “Learning Social Medicine – Medical students’ perspectives from Germany”

Chair: Amand Fuhrer, Martin Luther University Halle-Wittenberg, Germany

In German medical curricula, social medicine is often absent or marginalized. It is squeezed into too few hours or voluntary courses, and only rarely part of medicine’s board examinations. Hence, social medicine suffers from a lack of time and low prioritisation, which shapes physicians’ self-ascribed role. The resulting reductionist biomedical gaze has been extensively criticised in the past decades, and research has shown that physicians’ lack of structural competency harms patients. To address this marginalized state, this panel aims to introduce three innovative approaches towards teaching social medicine and reports the perspectives of participating medical students.

1. Practice: Together Against Tuberculosis: Practicing Social Medicine through Accompaniment of Patients with Tuberculosis in Germany

Luisa Bock, Paula Engels, Robert Miller, Inga Pfuhl, Michael Knipper

Institute of the History, Theory and Ethics of Medicine, University Justus Liebig Giessen, Germany

Germany is a low-incidence country for tuberculosis, but communities affected by poverty, social, legal, and structural marginalization – including racism and xenophobia – are still disproportionately affected by this deadly and highly stigmatized infectious disease. The majority of patients have a history of migration, with the perilous conditions resulting of war, displacement, and complex migration routes, as well as precarious living and working conditions during transit and in Germany (e.g. in collective accommodations of refugees or low-wage-labour migrants, homelessness) leading to an accumulation of risk for TB-infection. The complex interplay of social and medical factors is further complicated by the long duration of TB-therapy, the frequency of severe comorbidities (e.g. mental health, multi-drug abuse) and multiple social and structural barriers for accessing health services (incl. lack of language mediation in health care). In response to this situation, an initiative of medical students started to provide assistance to patients with TB in the county of Giessen (central Germany) in 2017, host city of one of the largest reception centres for refugees in Germany. Through individual accompaniment and the creation of strong local network between medical school, university hospital, the local public health agency and social services, medical students support patients throughout the treatment process. In addition to helping –

and often saving – individuals suffering TB, students get to know the German health service from the perspective of a person affected by stigma and exclusion and give proof of the fact that through accompaniment and social medicine health equity – e.g. 100% treatment completion – is achievable.

2. Theory: Reading Liberation Medicine – Approaching Social Medicine through the Rebel Body

Jonathan Bay, Larissa Chandra, Kyana Diehl, Conrad Drünert, Lea Hofmann, Henrike Höfer, Laura Höhs, Janka Massag, Shayan Rezaei Shayesteh, Elsa Strauß, Emma Thrandorf, Amand Führer

Institute for Medical Epidemiology, Biometrics and Informatics, Martin Luther University Halle-Wittenberg, Germany

The course we want to present was part of the study program in medicine. In conception, the course adopted teaching methods from the social sciences, exploring Liberation Medicine through weekly critical readings and discussions. Liberation Medicine, a term that was primarily shaped by Nancy Scheper-Hughes (1992), aims to conceive a medicine that strives for “new ways of addressing human misery”. Thus, our reading started with epistemological texts that interpret illness as a form of rebellion and resultantly demand that physicians should react to systemic inequalities with a “preferential option for the poor”. In the following weeks, ethnographic texts and examples for practical applications of Liberation Medicine guided our discussion and raised the question how the ideas of Liberation Medicine could be translated into daily medical practice and actionable change within healthcare systems.

These debates were facilitated by an open discussion format, which created a supportive environment for critical thinking, exchange of experiences, and reflections on the every-day realities of medical training. This format allowed us to start thinking about ways to improve medical training and clinical practice. Through the engagement with simulating texts, this course created space for critical thinking and discourse, which is often lacking in the rigid structure of medical studies. This challenged us to rethink our roles as future physicians in an interdisciplinary context, striving to become healthcare professionals who are compassionate, socially conscious as well as structurally competent.

3. Action: DiverMed – Integrating diversity sensitivity into medical training

Fiona Eichhorn, Christine Holmberg

Institute for Social Medicine and Epidemiology, Brandenburg Medical School
Theodor Fontane, Germany

Enabling students to practice Social Medicine in everyday care is the focus of DiverMed, a project that aims to systematically integrate diversity sensitivity into medical education. The curriculum is theoretically grounded in ecosocial theory and intersectionality. Nancy Krieger's ecosocial theory examines the interplay between biological, social, and ecological factors affecting health. Intersectionality explores the overlapping dimensions of social categories that shape social positioning and experiences. DiverMed is longitudinally integrated into the medical doctor education. Theories are introduced in the second semester during a semester-long Health Sciences seminar. Throughout the Brandenburg Medical Model Curriculum (BMM), these theoretical foundations are revisited in various interdisciplinary seminars. Case vignettes are incorporated as a central teaching tool, providing students with practical scenarios to apply their clinical knowledge alongside the theoretical concepts. Case vignettes are developed from interview studies interrogating health services, care and illness experiences from patients and health care providers. These inputs are transformed into fictionalized, yet practical and easily comprehensible scenarios tailored to specific topics. By incorporating cases that stem from the everyday care experiences, the vignettes encourage students to reflect on their roles within the healthcare system. This approach shall foster sustainable engagement, simulate interest, and initiate discussions about solutions to challenges in the healthcare sector. These vignettes are particularly valuable in the clinical semesters (semesters 8–10), where they help bridge the gap between theory and practice, enhancing the integration of theoretical insights into clinical decision-making and patient care.

1D: Mental health/care

*Chair: Francisco Ortega, Catalan institution for Research and Advanced Studies /
Universitat Rovira i Virgili, Spain*

Carol Wilson - Caught between a sinking land and an encroaching sea: Complexities of ethnographic health research in the context of climate crisis in coastal Kerala, India

Fiona Stirling and Lauren Hempseed - Mental health practitioners with experiences of

self-injury: Towards building understanding and making system change

Gabriel Abarca-Brown - Haitian Migration, Moral Economies, and Religious Experiences in an Evangelical Church in Santiago, Chile

Francisco Ortega - Integrating social medicine into primary care: Community-based suicide prevention intervention in the Filipino community of Raval, Barcelona

Caught between a sinking land and an encroaching sea: Complexities of ethnographic health research in the context of climate crisis in coastal Kerala, India

Carol Wilson, Jawaharlal Nehru University, India

Climate change projections have undeniably warned about the impact of a warming planet in countries of the global south. Communities situated in fragile, marginal ecologies, with existing socioeconomic vulnerability and limited adaptive capacity, are the most vulnerable to the health impacts of the climate crisis. In such contexts, the theoretical underpinning of emotional political ecology provides a critical lens for understanding the lived experiences of environmental transformations that structure the indigenous experience of psychosocial distress. The interdisciplinary framework of emotional political ecology enables research on mental health to be placed within the context of local environmental changes and macro dimensions of climate change. Drawing from the findings of an ethnographic research conducted with a coastal community in Chellanam, a village on the southwestern coast of India, this paper highlights the interlinkage of socio-political, economic, and ecological factors that expose a historically marginalized community to the impacts of environmental crisis. Sandwiched between the Vembanad estuary and the Arabian Sea, Chellanam endures slow disasters of tidal flooding and coastal erosion in their everyday life. Infrastructural damage and health issues emerging from increased salinity due to sea level rise add to the miseries of the already overburdened lives. This paper thereby foregrounds the necessity to locate emotional health as intertwined with already existing socio-economic vulnerabilities to address the overall health of communities at immediate risk of climate change impacts.

Mental health practitioners with experiences of self-injury: Towards building understanding and making system change

Fiona Stirling and Lauren Hempseed, Abertay University, UK

Mental health practitioners with experiences of self-injury face stigma in both professional and personal contexts. Their experiences with mental health, marked visibly upon their body, can signal them as somehow inadequately skilled to work within the health system. Yet, what if their experience may in fact provide unique strengths? Research to establish understanding around this population and how they manage disclosure/non-disclosure within their professions has been neglected thus far. This limited insight impacts the acceptance, awareness, and inclusion of practitioners with such lived experience; ultimately limiting valuable diversities of knowledge and approaches to caring within mental health services which could reduce stigma for professionals and service users alike. It also limits conceptions of what 'health' can look like, stifling the emergence of alternative discourses. Approaching from the perspective of their own lived experience of self-injury the presenters will consider: existing literature around the experiences of professionals in contexts such as clinical psychology, counselling, and mental health nursing; the limited policy guidance for professional bodies around supporting practitioners with lived experience; and the current absence of exploration of this topic in training education. We will outline our current research plans to understand more about the experiences of such professionals and gather input from the audience to generate further creative ideas. Overall, we hope to inspire future research in this area in order to heal the systemic faults harming practitioners and service users alike.

Haitian Migration, Moral Economies, and Religious Experiences in an Evangelical Church in Santiago, Chile

Gabriel Abarca-Brown, University of Copenhagen, Denmark

In this presentation, I will explore the interactions between Evangelical churches and Haitian migrants, paying particular attention to both the moral economies involved and Haitians' religious experiences. Based on a multi-sited ethnography conducted over 14 months in 2018 and 2019 in the north of Santiago, I will argue that Evangelical churches have become spaces where institutional agendas, religious practices, and the experiences of Haitians intersect, shaping a variety of moral economies that validate the churches' institutional mission while also acknowledging Haitians' individual and collective experiences. This article highlights how this variety of moral economies is anchored in a broader socio-historical context. Specifically, it emphasizes how different politics and ideologies have

strengthened Evangelical institutions and actors from the civil-military dictatorship (1973-1990) to the post-dictatorship neoliberal times (1990-2019), as well as how they have shaped the relationship between these institutions and actors with health services in Chile.

Integrating social medicine into primary care: Community-based suicide prevention intervention in the Filipino community of Raval, Barcelona

Francisco Ortega Universitat Rovira i Vigili, Tarragona, Spain

This presentation examines one initiative that arose from primary care based on community and social participation, around Suicide Prevention Gatekeeper Training. The intervention addressed the Filipino community living in the multicultural and socially deprived neighborhood of “El Raval” in Barcelona. The intervention involved training community gatekeepers with the knowledge and skills to identify and respond to individuals exhibiting signs of suicidal behaviour and addressing knowledge and skills gaps among primary care professionals around suicide risk management. The intervention underscores the indispensable role of primary care (PC) in identifying community needs and services to address them effectively. It also emphasizes the following key insights to integrate community health and social medicine principles into primary care: a) Promoting community-centred approaches in primary care; b) addressing systemic inequalities; c) boosting adaptability of primary care; d) Supporting community health initiatives; e) promoting evidence generation and recognition.

Integrating community health into primary care may be a response to immediate challenges but also a transformative strategy for building equitable and sustainable healthcare systems. By building health assets and fostering a culture of shared responsibility, the initiative demonstrates the potential of community-based approaches to drive sustainable improvements in mental health outcomes. This intervention draws on social medicine and structural competency approaches that emphasize the social, historical and structural factors that influence health and healthcare. Global social medicine promotes horizontal cross-community learning and solidarity, the reinvention of democratic civil society, and the creation of infrastructures that support self-determination and community participation.

Co-author: Josep Barceló-Prats

1E Antibiotics as global objects: The paradoxes of access and excess

Moderator: Heidi Fjeld, University of Oslo, Norway

Andrea Butcher, University of Helsinki, Finland

Amanda Hylland Spjeldnæs, Anne Kveim Lie, Lise Bjerke and Sine Grude, University of Oslo, Norway

Both overuse and underuse of antibiotics contribute to the spread of antimicrobial resistance (AMR), and while reducing the consumption of antibiotics is at the centre of global health campaigns, the unequally distributed lack of access to effective antibiotics is more peripheral to these policy debates. This roundtable discusses the paradoxes of access and excess with a particular focus on low and middle-income countries (LMICs), and is organised into three parts: the triple burden of AMR in LMICs; global pharmaceutical supply chains; collaborative initiatives to enable more sustainable and effective use of antibiotics. We take results of the interdisciplinary project *From Asia to Africa: Antibiotic trajectories across the Indian Ocean* – a project that investigates how active pharmaceutical ingredients (APIs) and generic antibiotics are produced and exported from China and India, and imported, regulated and consumed in Tanzania – as a starting point and discuss an inclusive social science research agenda that highlights 1) antibiotics as global objects and 2) the broader structural and context-specific conditions that underlies antibiotics use, and 3) collaboration as central to intervention development. We ask how mapping and theorizing production and consumption practices can inform action to improve equal access to, and sustainable use of, essential antibiotics.

2 - Saturday 15.00 - 16.30

2A: The system is working as intended – critical perspectives on global health and complexity in colonial violence

Rhiannon Mihranian Osborne, University of Liverpool, UK

Dr Sara el-Solh, NHS Scotland, UK

Layth Hanbali, Institute for Palestine Studies

The word ‘global health’ has become synonymous with an industry of academia, NGOs and business with the stated intention of working towards shared healthy futures. However, today and historically, this industry has demonstrated an inability to respond to the health consequences of colonial capitalism and, at worst, been actively complicit in enabling structural violence. This has been highlighted by the ‘global health’ and medical response to the genocide in Gaza, ranging from silence to

active suppression of pro-Palestinian voices to limited humanitarian appeals. This roundtable uses the case of Palestine to explore how colonial and capitalist structures underpin global health inequalities, and the harms of an industry that refuses to name this, despite its own claims of ‘decolonisation’. We will examine the role of global health institutions in legitimising and sustaining systemic violence such as settler colonialism. We will contrast this with our perspective, as organisers and campaigners, on the upsurge in anticolonial action by health workers acting through a global justice lens. This includes the role of health workers in protest, combating propaganda, medical solidarity, direct action, and union organising. We will discuss the potential of a growing intersectional understanding of health, oppression and solidarity which can be put into action to disrupt structural violence. We will use the No Palantir in the NHS campaign as a case study, which spans Palestine solidarity, AI weaponry, privatisation and outsourcing, health securitisation and data rights, and has mobilised thousands of people in the UK.

Practice: This panel explores the roles and responsibilities of health workers in the context of global colonial capitalism and systemic violence, especially in the setting of increasing securitisation and militarisation of healthcare, coupled with the active targeting of the health of colonised people. The panellists are actively involved in practices of medical solidarity.

Theory: This panel challenges conventional understandings of global health as an ‘apolitical’ public health practice. Instead, by drawing on theories of structural violence and health justice, we critically engage with the architectures of power that shape health and wellbeing.

Action: The panellists are active organisers in movements for health justice and Palestinian liberation, and the panel will engage in the various ways health workers have intervened, advocated and disrupted and how this in turn shapes and builds new health paradigms. It addresses the urgency of building solidarity and collective action in the face of systemic violence, making it directly relevant to the shared goal of creating "healthy futures."

This roundtable builds on the recent article by panellists Dr Sara el-Solh and Dr Rhiannon Mihranian Osborne in the Lancet on this topic (The system is working as intended El-Solh, Sara et al. The Lancet, Volume 404, Issue 10462, 1520 - 1521). We will expand on the central argument that global health institutions are often at best silently complicit and at worst actively participating in structural violence, and that challenging this requires consciously naming the power structures driving this violence.

2B: Medical knowledge/s meet

Chair: Anne Kveim Lie, University of Oslo, Norway

Nils Graber - "Primarizing oncology: the case of primary healthcare cancer immunotherapy clinical trials in Cuba"

Chih-Ju Wu - Why autoethnography? Conducting Research to Reclaim Health Narratives for Children of Vietnamese Immigrants in Taiwan

Jonathan Kuo - Revisiting "The San Francisco Experience": Emotional Encounters and Intellectual Exchanges during the HIV/AIDS Study Tour

Monita Sowapark - Registers of Healing and Authority in Siam/Thailand

"Primarizing oncology: the case of primary healthcare cancer immunotherapy clinical trials in Cuba"

Nils Graber, Humboldt University in Berlin, Germany

In 2012, Cuba's Center for Molecular Immunology (CIM), a state biotechnology center, partnered with the Ministry of Health to organize a clinical trial of immunotherapy for lung cancer in primary health care centers (PHC), called polyclinics. The goal is to bring both innovative treatment and cancer care closer to patients' homes, while completing a Phase IV clinical trial that will provide "population data" on lung cancer survival. To some extent, this intervention can be seen as a "primarization" of oncology – i.e. an attempt to integrate cancer biomedicine into the long-standing framework of PHC, which is centred on prevention, participation, and social justice. At the same time, it can be argued that what is at stake is a "biomedicalization" or "pharmaceuticalization", since PHC is being transformed into a space of biomedical experimentation, where access to drugs and the production of data take precedence over PHC. In order to critically examine this case, I will first trace the genealogy of this program, which is part of a long-standing trend in Cuba to integrate locally produced biotechnology into the national health system as a means of both public health and export. In a second part, I will draw on my ethnography of this program -mostly between 2014 and 2017- to explore the tensions and alignments between oncology and PHC that are at stake. Overall, I argue that this Cuban case invites us to move beyond the framework of biomedicalization by examining practices of articulation between social medicine and biomedicine at different levels.

Why autoethnography? Conducting Research to Reclaim Health Narratives for Children of Vietnamese Immigrants in Taiwan

Chih-Ju Wu, National Yang Ming Chiao Tung University, Taiwan

Discourses about migrant health commonly and inevitably emphasize vulnerability, reinforcing narratives of exclusion, disparity, and deficiency. While these perspectives shed light on structural barriers, they often neglect the lived experience and agency of migrant communities. With the growing number of new immigrants in Taiwan, officials have pointed out that the foreign resident population—including migrant workers, marriage immigrants, overseas students, professional investors, and mid-level skilled labourers—has surpassed 1.6 million in a country with a total population of 23 million. However, research on migrant health remains limited, and the intricate ways in which cultural, economic, and social contexts interact to shape migrants' perceptions and health-related decisions have yet to be fully explored. As more scholars engage in this field, it is also important to avoid reaffirming prevalent negative narratives. Using autoethnography, complemented by in-depth interviews, this research examines how second-generation Vietnamese in Taiwan navigate their identities while encountering traditional Vietnamese medicine and modern biomedical practices and confronting the conflicts between Vietnamese and Taiwanese medical beliefs. Rather than assuming a linear assimilation trajectory, this study examines how cultural belonging, intergenerational knowledge transmission, personal lived experiences, and the pursuit of individual identity affect health practices. By positioning autoethnography as more than personal reflection—instead, as an evolving, relational, and activist practice—this study seeks to disrupt static migrant health narratives and contribute to a more nuanced understanding of the lived realities of Vietnamese second-generation immigrants in Taiwan.

Revisiting “The San Francisco Experience”: Emotional Encounters and Intellectual Exchanges during the HIV/AIDS Study Tour

Jonathan Kuo, Johns Hopkins University, USA

In 1989, three officials working in Leicester's AIDS sector flew across the Atlantic on a journey to San Francisco, the city they considered “synonymous with the problems of HIV and AIDS.” This trip, however, was no mere exercise in bureaucracy. The study, they explained, could offer a wealth of public health knowledge, on things like “health promotion initiatives” and “community action programmes.” As they visited over twenty organizations in their two-week trip, they discovered it was a vividly emotive process, narrating experiences like dressing like prostitutes to distribute condoms, attending an ACT UP meeting, and donating blood (and fainting). Centred

around these two short weeks, this project seeks to bring together three historiographical strands underdeveloped in the scholarship on AIDS in the UK, drawing from newspaper reports, advertisements, organizational records, government files, letters, and other archival sources. I argue that Leicester is central to our understanding of AIDS as the first city outside London to create a stable Black HIV/AIDS group, a fact omitted so far in the literature. This omission comports with a scholarly blind spot in race in the scholarship on AIDS, which has historically trended toward political and social histories. But, attitudes toward and constructions of race and racism, I argue, were just as instrumental to responses to AIDS. Last, I begin to explore the role of emotion in shaping health responses to AIDS. Through these analyses, I demonstrate the importance of transnational exchanges in shaping responses to infectious disease, socially, politically, emotionally, and practically.

Registers of Healing and Authority in Siam/Thailand

Montita Sowapark, University of Pennsylvania, USA

During his visit to Siam in the early-20th century on behalf of the Rockefeller Foundation, Victor Heiser commented on the inadequacy of the Thai language for modern science: “Textbooks in Siamese could not be kept up-to-date because the language lacked the means for expressing recent medical terminology, and consequently neither teacher nor student was able to avail himself of scientific discoveries as they occurred” (Heiser 1936, 486). This paper asks: What was medical practice and theory in Siam prior to Western biomedicine? How were issues of linguistic representation, communication, and translation managed as Western biomedicine became more prominent throughout the 20th century? By analysing pre-biomedicine Thai medical texts and their uptake, I argue that there is more commensurability between the two systems than is commonly conveyed. I argue that accounts of Thai medicine by Western missionary-physicians emphasized a subset of practices Westerners considered primitive/illogical/incomprehensible and ignored large aspects that were practically useful, evidence-based, and commensurable with Western biomedicine. This myth of incommunicability justified movements to rationalize and “civilize” Thai medicine and medical education, which served to produce a skilled class of emigrants poised to work as health professionals in Western countries. However, as Americans and Europeans understood their work to “improve” medicine and health in Thailand as part of a first, proselytizing, and then, civilizing mission, Thai elites have also utilized medicine as a site for metapragmatic struggle of authority towards nationalistic aims.

2C: The Case Series in Global Social Medicine: an inter-disciplinary toolkit:

Chair: Mayssa Rekhis, University of Gothenburg, Sweden

Seth M. Holmes, Berkeley Center for Social Medicine, USA

Yi-Cheng Wu, Hsinchu Mackay Memorial Hospital and Mackay Medical College, Taiwan

Zohar Lederman, University of Hong Kong, Hong Kong

Mirko Pasquini, University of Gothenburg, Sweden

Jeremy Gottlieb - University of California, San Francisco

Healthcare research and practice are in urgent need for the social sciences, but most social sciences' research and perspectives is not written and disseminated in a way that is useful and applicable to health professionals. To address this, our Case Series project focused on translating social sciences concepts into practical tools derived from (and useful in) various clinical contexts, and produced a practical toolkit that can be mobilized in health professionals' education. This toolkit is composed of practical cases to equip health professionals with tools from social medicine to tackle inequalities and navigate related social, ethical, and structural dilemmas they face in their own contexts and clinical practices. The case format – well-known in medical education, medical practice and medical publishing – was chosen for bringing social medicine concepts to clinical audiences. Co-authorship by a team of health professionals, social scientists and humanities scholars (including dual-trained health professionals) was key in bridging the disciplines. During this roundtable, we will discuss the process of bridging the various disciplines during the project including our success and failures. We will describe the design of an intensive residential writing workshop that allowed experts from all over the world to meet and support each other to develop the cases. Our aim with this roundtable is to learn from others, enable others to learn from us, and to better prepare for the next interdisciplinary workshop. Lastly, we will examine how health knowledge and social science theory integrate to effectively elucidate the social determination of health and suggest interventions to do things differently and tackle health inequities.

2D: Care outside of healthcare

Chair: Helena Hansen, Professor and Interim Chair of Psychiatry and Biobehavioral Sciences at UCLA's David Geffen School of Medicine, USA

Magdalena Jadwiga Härtelova and Cassie Thornton - The Hologram project, a peer to peer health monitoring protocol

Nadia Lucia Peralta - Social Dreaming and Impractical

Thinking: Reflections on Mutual Aid and Community Resilience in a Time of
Converging Crises

Natasa Stoli - Do-it-yourself hormones: Providing an alternative

The Hologram project, a peer to peer health monitoring protocol

*Magdalena Jadwiga Härtelova, Casino for Social Medicine, and Cassie Thornton,
Feminist Economics Department (The FED)*

For the past eight years, we have organized a peer-to-peer health monitoring project called The Hologram (Cassie Thornton: *The Hologram: Feminist Peer-to-Peer Health for a Post-Pandemic Future*, Pluto Press, 2020). The meeting protocol that is at the heart of this project was inspired by the Integrative Care Model used by the Group for Different Medicine that has been operating the free social solidarity clinic KIA in Thessaloniki for the past thirteen years. The Hologram translated their non-hierarchical holistic approach to medical diagnosis into a non-professional mutual aid context, which has since been used by thousands of people all over the world. The virally spreading method for an autonomous care structure has been supported by an ever growing team of organizers who have held public courses, facilitated hundreds of sessions both online and in person, translated the book and materials into at least ten other languages, and conducted participatory research about the long-term effects of this self-organized support system.

For the European Conference on Social Medicine, we would like to focus on presenting three areas of our findings. One, we want to show the adaptation process of a medical method to be accessible by people from various educational and cultural backgrounds. We will demonstrate how our experience from popular education and social organizing informed a protocol that is easily adaptable (in the style of NHS “social prescribing”) and holds space for different crises situations as well as for long-term support. We will present our re-visit of the KIA clinic that took place in December 2024, where we compared our experiences with the doctors and volunteers from the clinic. Secondly, we will propose our theory of change that has developed over the years of our use of the Hologram protocol. We will demonstrate how thorough and long-term peer support influences not just the individual receiving it, but those who give, as well as everybody in their vicinity. We have been able to track the change in the quality of life and approach to care systems in individuals using the protocol for over four years. Lastly, we would like to present our newest Hologram-affiliated project, the Casino for Social Medicine in Berlin. In this venue, we have used our findings from the Hologram to set up small interventions and

programming that battles alienation, upskilling everybody in social interventions, communication, and mutual aid strategies.

Social Dreaming and Impractical Thinking: Reflections on Mutual Aid and Community Resilience in a Time of Converging Crises

Nadia Lucia Peralta, Cabrillo College, USA

This presentation is a practice of social dreaming based on experiences of mutual aid efforts that emerged as a response to the Covid-19 pandemic between 2020-2024 in the town of Santa Cruz, California. I will reflect on my experiences participating in a mutual aid herbal collective, as a member of Campesina Womb Justice– a mutual aid group for Indigenous Mexican and Central American people who menstruate and raise children while working in abject conditions in the agricultural fields of Watsonville, CA– and my own personal experience accompanying an elderly African-American neighbour in need of housing and medical care. Through the lenses of situated cosmopolitics, structural competency, and feminist science refigurations, I will frame these experiences as case studies in the practice of enacting theory and the gaps that remain between theory and practice. Drawing on the theoretical framework of “impractical thinking” (Neff et al., 2019), I will expand on the dialectical tension between imagination and practicality, environmental well-being and social health, and what is and what could be – not only as a way to touch the seemingly impossible, but as a way to remedy grief, disappointment, burn-out, and fuel personal and collective resiliency.

Do-it-yourself hormones: Providing an alternative

Natasa Stoli, Maastricht University, The Netherlands

Hormone replacement treatments (HRT) are an indispensable aspect of transgender healthcare. And yet, recent shifts in the political climate worldwide have made access to HRT far from a straightforward matter. Using digital ethnography and thematically analysing data generated from an online forum, this case study explores a purposefully hidden community of transgender activists involved in do-it-yourself (DIY) medicine. This research argues that in response to inadequate healthcare services and a sense of frustration at the perceived state abandonment (or outright hostility), this community informally supports and cares for each other by producing hormones outside of the established boundaries of the global pharmaceutical arena. As these pharmaceutical products are produced at-home, with support and guidance from other community members, but with complete lack of top-down supervision by certified experts in the field of biomedicine and a grey legal status, they provide a grassroots alternative to formal healthcare services, in a community that engages in

medical citizenship, claiming their rights to their own bodies, often in direct opposition to governmental policies.

2E: The Practice and Praxis of Structural Ableism in Healthcare

Chair: Jennifer Baldwin, University of Pittsburgh, USA

Kristen Ann Ehrenberger, University of Pittsburgh and Jennifer L Baldwin, UPMC Children's Hospital Pittsburgh

Just as structural racism is responsible for the systematic oppression, exclusion, and discrimination of minoritized, Black, Indigenous, and People of Colour across domains of education, housing, employment, and healthcare, structural ableism likewise mounts physical, mental, procedural, economic, political, and institutional barriers to the full inclusion of people with disabilities (PWD). However, the constructs of “accessibility” and “ability” have received less theoretical and thematic attention in structural competency frameworks and US-based initiatives focusing on diversity, equity, and inclusion (DEI). This panel opens a space for dialogue across healthcare specialties and systems; the medical humanities, social sciences, and clinical sciences; and across the Atlantic Ocean in order to generate a praxis of structural ableism in healthcare that is practical and actionable. In the first part of this session, we will first define structural ableism and provide illustrative examples from our respective clinical practices and medical training within the US healthcare system. In the second part, we will facilitate a dialogue amongst audience members to solicit examples of convergence and divergence with regards to the definition of structural ableism, as well as the experiences of structural ableism across different health care and medical education systems and settings. The goal of this dialogue is to strengthen a working definition of structural ableism, as well as participants’ ability to identify and critically engage with the structural forces that shape the lived experiences of PWD in diverse healthcare and societal contexts.

3 - Sunday 10.30-12.00

3A: A politics of solidarity / a politics of humanitarianism

Layth Hanbali, Institute for Palestine Studies, James Smith, University College London, UK, Gassan Abu-Sittah, American University of Beirut, Lebanon

A commitment to humanitarian principles, particularly neutrality, dominates the discourse of most organisations (formal or informal, local or international) involved

in care and service delivery in crisis settings. Such settings are becoming increasingly pervasive, driven by growing fractured states in the context of end-stage neoliberal capitalism. Many crises are even considered perpetual or permanent. Anticipating collective futures in which states of crisis are commonplace, it is imperative that we draw our attention to the politics of everyday caregiving in such situations, and the principles, systems and structures that give shape and form to crisis care. Indeed, the political drivers of these crises drive many health activists to question the hegemonic humanitarian insistence on neutrality, especially as, often, the same structures that cause the crises are brought in to deliver humanitarian aid to mitigate their harms. This scepticism is intensified by the well-evidenced and commonplace instances of white saviourism, investigations of which uncover racism, exploitation, sexual violence and abuse throughout the humanitarian sector. Many practitioners are instead looking to practise solidarity, inspired by suppressed historical practices of social movements and transnational liberation struggles. Drawing from recent experiences of working in Gaza, occupied Palestine, during an escalation in Israel's longstanding genocidal violence against the Palestinian people, this roundtable will explore overlap and divergence between a politics of solidarity and a politics of humanitarianism in contemporary crisis care. In so doing we can trace more clearly the contours of health futures that are much more confidently and genuinely rooted in a commitment to solidarity.

3B: Anti-colonial, anti-capitalist and more-than-human health reimaginings

Chair: Bram Wispelwey, Harvard T.H. Chan School of Public Health, USA

Deena Ayesh - Reimagining a liberated health system in Palestine: the frameworks of abolition medicine, anti-settler colonialism, and indigenous health

Surasya Guduru - Disrupting the Colonial Clock: Rethinking Time, Healing, and 'Compliance' in Medicine

Yasir SP - Arrhythmias of Colonialism: Chronic Illness and the Temporalities of Occupation in Palestine

Davina Kaur Patel - Braiding Together Social Medicine, Ecologies and More-than-human Health

Reimagining a liberated health system in Palestine: the frameworks of abolition medicine, anti-settler colonialism, and indigenous health

Deena Ayesah, New York University, USA

The health system in Palestine exists at the intersection of settler-colonial occupation, structural violence, and systemic oppression, presenting unique challenges to achieving health equity and sustainable healthcare reform. This paper reimagines a liberated health system in Palestine by engaging with the combined strengths of health frameworks in abolition medicine, anti-settler colonialism, and Indigenous health, which offer alternative theories for addressing healthcare injustices. Abolition medicine challenges foundational structures of medical institutions that perpetuate inequality, advocating for the dismantling of harmful systems and the creation of alternative, healing-oriented frameworks. Anti-settler colonialism critiques the displacement and exploitation of native populations for establishment of a new colonizing population, analysing the ways in which native health practices, sovereignty, and access to care are disrupted. Indigenous health frameworks prioritize the healing and well-being of indigenous communities through a decolonized approach, centring traditional knowledge and community-led care models. A liberated Palestinian health system must address not only immediate health needs but also actively dismantle the colonial structures that hinder its development. Drawing on these principles, this analysis assesses models for a sustainable, self-determined healthcare system that transcends colonial legacies and embodies a vision of collective liberation. In doing so, this analysis advocates approaches to health system development that integrate theory, practice, and action to foster a healthier, more equitable future for Palestine and beyond. By grounding this vision in actionable solutions, this work envisions a health system which honours lived experiences, resists structural violence, and embodies resilience, accountability, and health justice for all.

Disrupting the Colonial Clock: Rethinking Time, Healing, and ‘Compliance’ in Medicine

Surasya Guduru, UNC Chapel Hill Gillings School of Global Public Health, USA

Western medicine operates within a rigid, linear temporal framework, privileging efficiency, standardized treatment protocols, and rapid recovery timelines. Yet, across cultures, time—and healing—function differently. This presentation critically examines how the imposition of biomedical timeframes, rooted in colonial and capitalist structures, marginalizes patients whose healing processes do not conform to Western expectations of progress and compliance. Racialized patients are disproportionately labelled “non-compliant” or “treatment-resistant” when they

engage with care on alternative temporal terms, obscuring the systemic nature of their health struggles. Drawing on Afrocentric and ancestral models of cyclical and nonlinear healing, I argue that the dominance of Western medical time reinforces racial health disparities and limits holistic care. This presentation will propose a framework for “temporal sovereignty” in medicine—the right to heal in one’s own time. Through interdisciplinary analysis of historical, sociocultural, and clinical perspectives, I examine how shifting temporal paradigms can transform clinical encounters and the management of chronic illness. Through interrogating the politics of time in medicine, this presentation offers a radical rethinking of healing beyond capitalist productivity, opening pathways for new, culturally-responsive and equity-centred healthcare models.

Arrhythmias of Colonialism: Chronic Illness and the Temporalities of Occupation in Palestine

Yasir SP, University of Toronto, Canada

Palestinians have some of the highest, continuously rising, rates of chronic illness in the world. Living within the context of the longest military occupation in modern history, generations of Palestinians have now continuously experienced both “episodes” of accelerative violence, as well as the everyday, “slow violence” of the occupation regime— violence which debilitates health slowly and uncertainly. In the words of Palestinian physician Osama Tanous (2021), “wars have become more chronic and diseases have also become more chronic.” Based on my current ethnographic research project on illness and temporality in Palestine, consisting of participant observation and ethnographic interviews, this paper traces the effects of the temporal structure of Israeli occupation on Palestinian bodies. I attend to architectures of temporal violence (checkpoints, landfills, permit regimes) to reveal the central role of health in de/colonial struggle. Particularly, I argue that the co-constitution of accelerative violence and slow violence aims to debilitate Palestinian health, memories, and futures, and refigures metrics of diagnoses, treatments, and experiences of disease. I explore the role that biomedical frameworks play in this de/politicization of illness under occupation, and describe the need for health frameworks which resist these colonial structures and events. To this end, I propose a reappraisal of the body itself: How might the colonized body — its elusion of total capture (Fanon 2004) — help generate alternative, anti-colonial conceptions of health, time, and history?

Braiding Together Social Medicine, Ecologies and More-than-human Health

Davina Kaur Patel, University of Oslo

This paper aims to connect social medicine with a growing body of more-than-human/ multispecies scholarship within the social sciences amid intensifying environmental destruction and accelerating climate change. Drawing upon ethnographic insights into the situated socioecological crisis in Punjab (India), this paper calls for a broadening of social medicine's practice, theory and actions to embrace more-than-human life through an attentiveness to ecologies. Thinking with Nash's (2007) inescapable ecologies and Taylor's (2024) disabled ecologies, this paper mounts a provocation to rethink social medicine beyond anthropocentrism and to explore the emancipatory potential in broadening its ethics of radical care to other-than-humans and its purview to more-than-human ecologies. Such a move demands recognition that human and other-than-human health, wellbeing and life itself are mutually imbricated and intertwined. Moreover it necessitates reflection upon the ethical injustice of valuing the health of other-than-humans as less than that of humans, and understanding other-than-human agencies. Whilst holding firmly onto social medicine's deep commitments to addressing intersectional inequalities, oppression and injustice, this paper seeks to ask how more-than-human injustices and ill-health are interlinked, recognizing the colonial and racialized common roots of nature/ culture and European/ non-European divisions and hierarchies. How might we as social medicine activists and scholars conceive of and make steps towards more-than-human flourishing, justice and health? How do we collectively build a social medicine that strives for just, equitable and emancipatory healthy futures, yet simultaneously is critical towards the anthropogenic pursuit of human health at all costs and the ecological destruction implicated. How can social medicine contribute to such more-than-human emancipatory futures through radical practice, theory and action?

3C: Reconfiguring medical education and practice

Chair: Iveris Martinez, California State University Long Beach, USA

Denis Regnier - Educating for Equity: Embedding Social Medicine in the Academic Programs of the University of Global Health equity

Nele Jensen - Rebel Doctors and Experiments in Response-ability

David Jones - Social Medicine Under Threat

Educating for Equity: Embedding Social Medicine in the Academic Programs of the University of Global Health equity

Denis Regnier, University of Global Health Equity, Rwanda

The University of Global Health Equity (UGHE) in Rwanda, founded by Partners In Health under the visionary leadership of Paul Farmer, represents an innovative model for embedding social medicine into medical and public health education. As global health systems contend with persistent inequities, the integration of social medicine into academic curricula is an urgent necessity for training health professionals who can navigate the social, political, and economic determinants of health. This paper examines how UGHE operationalizes the tripartite framework of practice, theory, and action to cultivate socially responsive health professionals. Through an interdisciplinary curriculum, UGHE integrates critical social science and humanities perspectives, community-based learning, and applied research to prepare graduates to challenge systemic health inequities. Drawing on my personal experience as Head of Humanities and Social Sciences at UGHE, as well as on student interviews and curricular analysis, this presentation explores pedagogical strategies that can be employed to instill a social medicine ethos in future health leaders. The paper also considers the broader implications of UGHE's approach for global health education, particularly in fostering a workforce committed to equity-driven action. By reflecting on UGHE's model, this paper contributes to ongoing discussions on how medical and public health training can move beyond biomedical paradigms to embrace the structural, historical, and social dimensions of health.

Rebel Doctors and Experiments in Response-ability

Dr. Nele Jensen, King's College London, UK

That medicine has become progressively reductionist in terms of its epistemological, methodological and practical orientation is part of what has been referred to as 'the standard social science critique' of medicine (Lawrence and Weisz 1998). And yet, such critique also risks treating medicine as a monolithic field while ignoring the many spaces of creative subversion and radical re-imagination that already exist in what critical biomedicine scholar Monica Greco calls 'the interstices' of institutional medicine (Greco 1998). Science and Technology Studies (STS) have challenged over-determined accounts of a monolithic medicine by foregrounding its 'multiplicity' (Mol 2002) and continuously shifting boundaries as a result of controversy and contestation (e.g. Wahlberg 2007; Brosnan, Vuolanto, and Danell 2018). And yet, radical challenges to conventional medical knowledge and practice are usually credited to patients and activists rather than medical doctors themselves

(e.g. Epstein 1996; Callon and Rabeharisoa 2008). In this talk, I discuss Integrative Medicine as a burgeoning medical movement that explicitly claims to overcome medical reductionism in favour of a ‘whole-person’ approach to health and healing. Drawing on a set of preliminary interviews with Integrative Medicine doctors in the UK, I ask not just what we might learn from engaging with medical ‘critiques from within’ (Mann and Chiapperino 2023) but also how we might cultivate a mode of constructive scholarly engagement with practitioners who are already actively engaged in efforts to do medicine differently.

Social Medicine Under Threat

David Jones, Harvard University, USA

Harvard Medical School established a required course in social medicine in 2005. This course, its commitment to health equity and social justice, and the experiences gained by teaching it, provided the foundation on which other programs have been built for medical students, masters students, and PhD students at Harvard and with international partners. The course’s status as part of the required curriculum at HMS has always triggered a backlash from politically conservative students (and faculty) who perceived the course not as an essential part of medical education and practice, but as political ideology and indoctrination. Course faculty had to continuously refine their messaging to preserve their space in the curriculum. This effort has, to date, been successful. Over the past decade like-minded programs have been established at many medical schools across the United States.

Over the past five years, however, a powerful political movement has emerged that challenges the teaching of social medicine at medical schools across the United States. This movement is a many-headed hydra, incorporating different (and often inconsistent) agendas. State legislatures and the federal government have exhibited unprecedented willingness to use their many levers of power (e.g., direct oversight of curriculum, revocation of grants and other sources of funding, replacement of university leadership) to assert political control over medical school curricula. Efforts to teach about race, gender, health disparities, and climate change have been attacked most furiously. Social medicine educators in the United States who remain committed to teaching these topics must develop new strategies to defend and extend this mission.

3D: Interplay of harm and healing

Chair: Ketil Slagstad, Institute for History of Medicine and Ethics in Medicine at Charité, Berlin, Germany

Margot Sabina Mai - Rabbia e cura: Italian feminist politics of OBGYN violence

Harris Solomon - Glitch Medicine: Homicidal Nurses, Overrides, and the Automation of Clinical Labor

Mirko Pasquini - Structural competency to 'Defuse' the exploding of violence against emergency care workers in Italy: between research and public health interventions.

Olivia Holterman Entwistle - PVC Blood Bags, Biocompatibility and Biomedicine's Petrochemical Bind

Rabbia e cura: Italian feminist politics of OBGYN violence

Margot Sabina Mai, Harvard Medical School and Harvard University Anthropology Department, USA

My research examines the possibilities and limits of feminine solidarity in response to patient experiences of harm in women's healthcare. Over the past decade in Europe, women's experiences of harm while receiving sexual and reproductive care have come to join a global conversation on Obstetric and Gynaecological (OBGYN) violence. In Italy, where gender violence and the future of socialized healthcare are understood as acute national crises, advocacy against OBGYN violence enters a larger discourse concerning the cultural value of women's bodies and the tenuousness of Italian modernity. In my paper, I examine how a politics of anger—or in Italy, "rabbia"—fashions collective concern over gendered medical violence that spills beyond impacted patients to unite a community of feminists. Through a wildfire of protests, testimonials, legislative lobbying, and awareness raising campaigns, Italian activists not only vocalize the desire for better care but actively disrupt traditional claims to biomedical authority and fashion a new patient subjectivity centred around empowered injury. My research explores both the political potential and limitations of a community centred around such injury. Drawing from grounded fieldwork in Genova, I illustrate the extent to which patients impacted by OBGYN violence are diversely gendered, locally medicalized, and importantly intersectional. And writing toward an uncertain horizon of social repair and reproductive justice, I theorize "cura", or care, as inseparable from the felt experience of touch and the reciprocity of caregiving relationships.

Glitch Medicine: Homicidal Nurses, Overrides, and the Automation of Clinical Labor

Harris Solomon, Duke University, USA

This paper dwells in the shadows of medicine and asks what has become of clinical work under pressures of computer-mediated automation. It stems from an ethnographic project about “glitch medicine”: the increasing normality of errors, mistakes, and workarounds in hospital work globally. In a context of intensifying automation and medical errors, how do we evaluate the ideas, affects, and ethics of trust, expertise, and goodness of medicine’s workers? The paper examines the case of an American nurse named Redonda Vaught, who enabled the override function of her hospital’s automated drug dispensing cabinet due to a perceived glitch. She then administered an incorrect drug to her patient, who subsequently died. Vaught was arrested, lost her nursing license, and a jury found her guilty of criminally negligent homicide. Most commentaries on the Vaught case question if and how nurses should be held legally liable for medical errors. However, rather than a normative bioethical analysis, this paper examines the unequal forms of social and labour reproduction connected to care automation. Drawing on feminist scholarship in medical anthropology and STS, it details the situated actions of automated clinical labour. At the hinge between protocol and craft, and between healing and harm, automation in medicine is as much a story of vulnerability as it is one of authority: a story of glitches with life-and-death stakes.

Structural competency to 'Defuse' the exploding of violence against emergency care workers in Italy: between research and public health interventions.

Mirko Pasquini, University of Gothenburg, Sweden

While violence against health care workers is being progressively recognized as a serious problem in the healthcare industry, it remains an under- studied area of enquiry in global public health. Anthropologists have long observed that violence toward patients is tied to institutional care practices in multiple ways, including repression, misrecognition and silencing. But research on health care staff's experience of violence is still lacking. This paper aims to address this literature and policy gap by providing research on the daily experience of vulnerability to violence that health care providers face during their work. To do so, the paper ethnographically explores the effects and perception of violence against health care workers in an emergency department (ED) in northern Italy, a place with a dramatic escalation of violent incidents. The paper illustrates how the ED staff attended to the experience of suffering of potentially violent patients. In so doing, ED professionals shifted the responsibility of violence against them from violent individuals to violent

structures shaping health inequities. The paper thus argues that ED professionals display a structural competence perspective when dealing with violence. It further elaborates on how community-based initiatives and a formal training in structural competency can help prevent the unfolding of violence against health practitioners and work towards better health accessibility and equity for patients.

PVC Blood Bags, Biocompatibility and Biomedicine's Petrochemical Bind

Olivia Holtermann Entwistle, University College London, UK

Plastics and other petroleum-based materials have become ubiquitous in biomedicine, resulting in a reliance of healthcare on polluting petrochemical industries. In this paper I examine the poly-vinyl chloride (PVC) blood transfusion bag, made flexible by the plasticizer Di-(2-ethylhexyl) phthalate (DEHP), as an example of what Foucault described as 'positive iatrogenesis', in which efficacy and harm are inextricably intertwined. DEHP, added to give the bags flexibility, has incidentally been found to improve longevity of red blood cells and is now foundational to blood banking. However, DEHP is also a potential carcinogen and endocrine disruptor, whilst PVC production results in the emission of highly toxic compounds. This paper examines the contradictions inherent in the DEHP-PVC blood bag and thereby considers broader questions about biological-synthetic relations in healthcare. The paper explores how the characterization of DEHP-PVC blood bags as 'biocompatible' relies on an understanding of 'biology' as standardized and universal, and construes 'biology' narrowly as relating exclusively to the human body. This universalist view ignores 1) the differential distribution of DEHP exposure within the population; 2) the uneven distribution of toxic effects of PVC production; and 3) the non-human biologizes and environments that are also subjected to these toxic exposures. The paper concludes with an exploration of how the concept of 'biocompatibility' may be modified to account for a wider range of biologizes and thus provide a framework for reworking the biomedical-petrochemical relationship.

3E: Fracturing the Medical Student Habitus: Imagining Clinical Ethnography in Undergraduate Medical Education

Hannah Connolly, Will Schlesinger and Emily Jones, University of California, Los Angeles, USA

Seth Holmes, Berkeley Center for Social Medicine, USA

Social factors are the primary drivers of health inequity in the United States, and medical education has agreed that trainees should develop the skills to acknowledge

and address them (LCME 2022). However, there is evidence that medical trainees remain underprepared to address the social drivers of health in practice, despite curricular innovations dedicated to this aim (Neff et al 2020). Moreover, ethnographic data from an American medical school highlights that the traditional medical student habitus is incompatible with academic medicine's professed social justice aims (Connolly 2024). In this roundtable discussion, we will use the dual physician-social scientist trainee "fractured habitus" as a new point of entry into addressing this ongoing tension in medical education. Specifically drawing upon Schlesinger et al.'s (2021) "Doing and Seeing: Cultivating a "Fractured Habitus" through Reflexive Clinician Ethnography," we will reflect on our participation in clinical ethnography groups across institutions as a space for cultivating an alternative professional identity to the medical student habitus. From a historical perspective, we will discuss the goals of "good-enough ethnography" and pathways toward integration of clinical ethnography into undergraduate medical education (Messac et al 2014). Overall, we will engage clinical ethnography as a potential tool to fracture the medical student habitus in order to train medical professionals that not only recognize health inequity but also meaningfully engage in social justice efforts.

4 - Sunday 13.00 - 14.30

4A: Shadows of policy agendas

Chair: Heidi Fjeld, University of Oslo, Norway

Kilian Atuoye - Health in Shadows: A search for health equity in agrarian landscapes

Isabelle Audigé - Tragic Choices: Care and Access to Healthcare for Women Survivors of Sexual Violence in the Democratic Republic of Congo

Sandra Ziegler - How professionals deal with healthcare access restrictions for asylum seekers in Germany. Promoting equity through theoretical and practical insights from an ethnographic exploration

Tony Sandset - Neglecting to Death: Rethinking Power, Responsibility, and the Politics of Inaction in Global Health

Health in Shadows: A search for health equity in agrarian landscapes

Kilian Atuoye, Queen's University Canada, Canada

The Global South has been experiencing remarkable changes in response to multiple competing factors upstream development agendas such as the 'new' green revolution in sub-Saharan Africa, and social transformations from below. These changes leave in their paths direct health impacts, but also their 'shadows' have

emerged more strongly and consolidated into spaces of exclusion, marginalization, and vulnerabilities for certain segments of the population. This paper advances discussions towards the theoretical concept: 'Health in Shadows', as a framework for analysing spatial constellations, unequal social relations, and opportunities for meaningful collaboration for health equity in the complicated landscapes left behind by cycles of global agendas. We used a case study from Ghana to illustrate the usefulness of the concept "Health in Shadows" in three interrelated ways: 1) contextualizing and explaining health inequities among farmers left behind in cycles of agrarian transitions; 2) the influence of structural factors in webs of health risks and their associated outcomes such as rising burden of non-communicable diseases, and 3) opportunities for lateral and vertical collaboration among policy makers, services providers, and community members in promoting health equity for populations and communities living in the 'shadows' of agrarian transitions. We conclude by emphasizing the strengths and limitations of this budding theoretical concept for the attention of practitioners and critical scholars in an emerging decolonized global health space.

Tragic Choices: Care and Access to Healthcare for Women Survivors of Sexual Violence in the Democratic Republic of Congo

Isabelle Audigé, CESPRA, EHESS, France

The provision of healthcare in conflict zones presents profound ethical and logistical challenges, particularly in the Democratic Republic of Congo (RDC), where sexual violence is used as a weapon of war. This research examines the dilemmas faced by healthcare practitioners and humanitarian organizations in delivering care to women survivors of sexual violence within constrained resources and structural inequalities. Drawing on a four-month ethnographic study (September to December 2024) conducted in a socio-medical institution in Bukavu, this paper analyses the concept of "tragic choices" (Calabresi & Bobbitt, 1978) in healthcare allocation. The study is based on interviews with psychosocial workers and participant observations of consultations with survivors of sexual violence. It highlights the moral and ethical tensions arising from limited medical and psychosocial resources, leading to selective care based on subjective criteria. The necessity for survivors to narrate their trauma as a form of validation further exacerbates systemic violence within the care process. This study also interrogates the role of "empowerment" in post-trauma care. Women are expected to become "leaders" upon returning to their communities, a goal that, while well-intentioned, often functions as an adaptation to a violent social structure rather than its transformation. The paper questions whether healthcare in conflict settings can move beyond biomedical and psychosocial approaches to

incorporate a political dimension that challenges the conditions sustaining structural violence. By integrating practice, theory, and action, this research contributes to debates on healthcare ethics, access inequalities, and the intersection of social medicine and geopolitics. It calls for a reconsideration of care frameworks to ensure that access to treatment is not contingent on arbitrary conditions but is aligned with the principle of health for all.

How professionals deal with healthcare access restrictions for asylum seekers in Germany. Promoting equity through theoretical and practical insights from an ethnographic exploration

Sandra Ziegler, Heidelberg University, Germany

Access to healthcare for asylum seekers in Germany is restricted. Many services must be requested from the government on a case-by-case basis for up to three years. We aimed to understand how professionals navigate the legal restrictions they are supposed to implement through an ethnographic exploration in two refugee clinics across federal states. We conducted a three-month participant observation, evaluated 110 cost-coverage applications, compiled 40 free lists, and interviewed 25 professionals (healthcare, interpretation, administration, social work). Inductive qualitative, quantitative, and theoretical analyses were used to produce educational material for medical students and recommendations for practitioners. Our findings indicate that vague legal wording forces healthcare professionals and administrative actors to make discretionary decisions that can create significant barriers for asylum seekers in accessing needed care. Social categorization based on patient behaviour and Othering - shaped by political and media discourses - affects ascriptions of deservingness, impacting relationships and access to care. Based on identified governmental prioritization criteria, we developed recommendations for students and practitioners on how to write successful cost coverage applications. Using sociological systems theory to analyses rationales employed in the cost coverage process revealed a recurring switching between medical, legal, political, and administrative rationales. Actors experience moral and other forms of distress. They engage in processes of demarcation and adaptation in response to restrictions: professionals strategize to enable access to care but can also become (unintentional) enablers of restrictive migration policies. Consequently, we empower students to engage in self-reflection and structural analysis while upholding professional ethics and distancing themselves from powerful anti-immigrant rationales.

Neglecting to Death: Rethinking Power, Responsibility, and the Politics of Inaction in Global Health

Tony Sandset, University of Oslo, Norway

Much of social medicine analysis prioritizes active forms of harm—such as violence, austerity, or deliberate exclusionary practices—as central threats to health and well-being. However, this focus risks obscuring an equally, if not more, destructive force: neglect. Neglect, as a theoretical framework, allows us to examine how structural inaction, systemic disregard, and the slow erosion of care contribute to death and suffering on a massive scale. From the underfunding of essential healthcare systems to the abandonment of vulnerable populations in the wake of crises, neglect operates through omissions, denials, and absences rather than overt attacks.

This paper argues that neglect should be recognized as a core analytical category in social medicine that shapes health inequities as profoundly as active harm. Drawing on examples from health system failures, racialized disparities during COVID-19, and climate-related health neglect, I illustrate how inaction can be as violent as action. While social medicine has long sought to expose injustices in health systems, it has yet to fully grapple with the role of neglect as a structuring force. Neglect as an analytical framework expands and challenges the active power in biopolitics, necropolitics, and other perspectives, which all too often focus on the active and the visible. We must theorize neglect not as an unfortunate byproduct of broken systems, but as a political strategy that determines who lives and who is left to die.

4B: Epistemic in/justice

Chair: Nele Jensen, King's College London, UK

Lucia Mair and Awa Naghipour - Mind the gap! On knowledge, power and activism in medical teaching.

Alex Müller - Toward an ethics of epistemic justice: research on health inequities related to sexual orientation and gender identity in politically contested settings

Augustin Rigollot and Mathilde Doucerain - From Theory to Action: The Contributions of a Foucauldian Reading to thinking Therapeutic Education, Patient Empowerment, and Health Democracy as Sites of Power.

Mind the gap! On knowledge, power and activism in medical teaching.

Lucia Mair, University of Vienna, Austria, and Awa Naghipour, University of Bielefeld, Germany

Medical conditions, diagnoses and research areas that are historically understudied and underfunded are receiving increasing public and scientific attention in recent years. Health activists especially challenge this status quo, whether patients, relatives or healthcare professionals. For educators in the medical field, this public questioning of science itself can pose a pedagogical challenge but also open an entry point for a long-overdue paradigm shift in medical education. Based on empirical findings from a joint teaching/research project in Germany and Austria, we centre interviews with health activists to discuss current social movements bringing attention to knowledge gaps in endometriosis, “male” contraception, and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). We analyse these as cases of ‘undone science’, a concept originating in social movement studies and science and technology studies (STS), to capture the matrix and interplay of structural, political and cultural processes contributing to these gaps. Building on ‘undone science’ as a pedagogical tool in medical teaching, we argue, can foster critical reflection of one’s role as medical students, physicians, researchers who could themselves play an active part in socio-political change-making. By bringing activist interlocutors into conversation with medical students, we aim to create space for critical discussion of power in knowledge creation, and an understanding of the structural forces and logics behind these imbalances. We thereby cultivate a sense of structural humility (Hansen 2015), encouraging students to recognize and acknowledge the centrality of social movements and civil society in identifying areas as “worthy of more research” (Frickel et al. 2010).

Toward an ethics of epistemic justice: research on health inequities related to sexual orientation and gender identity in politically contested settings

Alex Müller, University of Cape Town, South Africa, & Charité Universitätsmedizin Berlin, Germany

In socio-politico-legal contested contexts, research findings on sexual and gender minority health enter into public discourse, advocacy and legal processes. This can benefit or harm sexual and gender minority groups. I analyse the ethical implications of this at individual and collective level. In this paper, I explore how health research on sexual orientation and gender identity is produced and interpreted within national and global political contexts and contributes to actively shaping political

decisions. Drawing on the experiences of a five-year-long participatory health research project and my involvement as expert witness in two strategic litigation cases, I demonstrate that in Southern Africa, research on sexual orientation and gender identity-related health inequities is both affected by, and has an effect on, the socio-politico-legal contexts within which these disparities exist, and mirrors global flows of knowledge, funding and ideologies. Within this context, I argue, we health researchers are agentic political actors rather than simply objective scientists. This has important ramifications for the practice of research, including ethics. Researchers access and direct knowledge, funds and resources across the globe and subtend powerful north-south flows. We work within contexts where sexual and gender diversity is highly politicised, and our findings are used to support arguments for or against LGBTQ+ rights, and thus directly or indirectly intervene in national political debates, health policy and legislative decisions. At the same time, our own identities can be mobilised by local or global forces either in favour of, or against, emancipatory efforts for the rights and well-being of LGBTQ+ people. Reflecting on the personal and professional decision-making processes that take place within this complex, multi-layered, contested and risky context, I underscore the individual and collective responsibilities that arise out of doing research on sexual orientation, gender identity and health inequities.

From Theory to Action: The Contributions of a Foucauldian Reading to thinking Therapeutic Education, Patient Empowerment, and Health Democracy as Sites of Power.

Augustin Rigollot and Mathilde Doucerain, University of Montpellier, France

In this work, we analyse health democracy and certain patient empowerment mechanisms through the lens of Foucauldian power relations, aiming to trace its contemporary genealogy within a hermeneutic circle that challenges the apparent linearity of patient rights' progress, often framed by new control institutions. We draw on a Foucauldian corpus, engaging with Deleuze and Negri's concept of the "society of control", to suggest that health democracy may not escape this dynamic but rather exemplify it. Our guiding question is whether medical power persists, disappears, or transforms within health democracy. After establishing the consubstantiality of medical knowledge and power we will see the implications for therapeutic education, expert patients, and narrative medicine. We critically assess what Guirimand (2015) calls the "pedagogization" of therapeutic education, questioning the role of medical supervision in it, drawing on the works of Tourette-Turgis et al. 2014; interrogate the role of expert-patient, whether it legitimizes patient experience or serves as an alibi for transmitting medical

knowledge through the patient's voice; and explore narrative medicine as a site for deconstructing medical knowledge and, by extension, physician authority. Ultimately, we reject both a simplistic reading of the Foucauldian corpus as a "global contestation of medicine" (Artière et al. 2001) or a power struggle between declining physicians and empowered patients, as well as a purely progressive, reformist view of patient rights. Instead, we argue that medical power is polymorphic: patients adopt avatars of medical power to legitimize their new role, while medicine itself re-legitimizes by shaping the very spaces it concedes. Rather than dissipating, medical power reinvents itself, disperses, multiplies, and internalizes within bodies and self-practices.

4C Social medicine - what holds it all together?

Chair: Raghav Goyal, Highland Hospital, Oakland California, USA

Alex Olirus Owilli, Equal Health, Anahí Venzor Strader, Harvard Medical School, Aarti Bhatt, University of Minnesota, Sara Soraya Eriksen and Suban Yusuf Mohamood

Social movements and justice are fragile. In progressive social medicine spaces, we wrestle with huge tensions: between our dreams and reality, between elite spaces and the *damnés de la terre*, between hope and despair, between being gentle and being militant, between purist ideals and the necessities of being in 'the system,' between the identities we love and those we don't, between political and spiritual work, between theory and praxis, between justice and mercy, between holding power accountable and remaining open to dialogue, even when it feels impossible. We find ourselves stretched, which perhaps is both uncomfortably necessary and necessarily uncomfortable. This workshop is focused on asking what holds it all together. There will be two primary threads: teaching and building. Teachers will reflect on their attempts at engaging in critical pedagogy and building critical consciousness in spaces previously devoid of it. Included are representatives from both "professional" and subaltern spaces, highlighting many forms of teaching: classrooms, social gatherings, hospitals, podcasts, popular education, social media, and zines. Builders will reflect on constructing, rattling, or getting access to the material sources of power, be those via activist collectives or monied authoritative institutions, and reflect on the failures or endings of those efforts. As we strive towards social justice through teaching and building efforts, we are confronted with soul-questions: what is movement building and what is that feeling—that so many of us have faced—of bringing something together and watching it dissolve and disappear? Is activism and good work a kind of constant yearning? What draws people from such different backgrounds to this work? Are we doing enough? How

would we know? How do we hold our compromises and complicities that are hard to part with? Is moral righteousness a helpful ideal or excuse for flagellation? How do we not reproduce systems of harm in our own spaces? Can we have open hearts in a world on fire? How can we make the revolution irresistible? As early socialist William Morris wrote, "Fellowship is heaven, and lack of fellowship is hell: fellowship is life, and lack of fellowship is death: and the deeds that ye do upon the earth, it is for fellowship's sake that ye do them." Reflecting together on the fellowship we want to live in even as we build it, this roundtable will serve as a space for collective reflection and story-telling about who we are, how we teach and share, why we do the work we do, and our dreams and fears for the world we hope to catalyse around us.

4D: Precarious labour

Chair: Seth Holmes, Berkeley Center for Social Medicine, USA

Alejandro Valdivia - Precarity-Based Evidence: Trade Unions' Knowledge Production on Migrant Workers' Occupational Health in Slaughterhouses in Germany

Roosa Sofia Tikkanen - Resistance to precarity: Examining labour union strategies and successes in advancing labour rights for Nepal's community health workers.

Amrita Limbu - Gender, Migration, and Registration: The Case of Women Doctors in the UK

Kwanwook Kim - Health-less Voice and Voice-less Health: Affective Labor and Techno-Moral Sickness in AI-Driven Korean Call Centers

Precarity-Based Evidence: Trade Unions' Knowledge Production on Migrant Workers' Occupational Health in Slaughterhouses in Germany

Alejandro Valdivia, HU Berlin (CMB) and Europa-Universität Flensburg (ICES), Germany

For years, grievances from low-qualified migrant workers in slaughterhouses were structurally overlooked, hindering the introduction of regulatory measures. It was only during the COVID-19 pandemic in 2020 that structural deficiencies were formally acknowledged, leading to the introduction of comprehensive regulations in the form of the Federal Occupational Health and Safety Control Act (Arbeitsschutzkontrollgesetz). Throughout the legislative procedure for this act, trade unions played a key role by providing sector-specific evidence on the necessity to impose limitations on employers' fundamental rights. This evidence was grounded in trade union knowledge, developed through years of fieldwork within the sector. This article investigates the rationality of unions' evidence and the

intricate dynamics of its development amidst structural precarity in the years leading up to the Arbeitsschutzkontrollgesetz. Based on the assumption that evidence is a condition for legal change which compels political actors to produce evidence-based claims, this article offers a case study-based discussion on the knowledge-policy interface within feminist Science and Technology Studies (STS). As a research strategy, it presents a theory/methods package of situational analysis within grounded theory, building on the concept of evidence-based policy (EBP) as an initial tool for empirical data analysis. The findings highlight how structural precarity forces a highly instrumental, partial and non-systematic approach to evidence development, conceptualised in this article as precarity-based evidence (PBE). Drawing on feminist STS, the study underscores the need to acknowledge PBE's positioned rationality beyond crisis-driven policymaking to ensure democratic participation of intersectional marginalised groups.

Resistance to precarity: Examining labour union strategies and successes in advancing labour rights for Nepal's community health workers.

Roosa Sofia Tikkanen, Norwegian University of Technology, Norway

Community health workers (CHWs) mostly work under precarious working conditions, characterized by informalization, low pay and no protection under labour laws. Labor unions and associations play a key role in negotiating strengthened labour rights for CHWs, but this area remains under-researched. This study examines female community health volunteers (FCHVs), Nepal's frontline primary care providers, and the role FCHV unions have played in advancing their labour rights. We collected data through 30 semi-structured interviews and five focus groups with FCHVs, national/local policymakers, FCHV union leaders, and I/NGOs engaged with FCHV programs in four districts, combined with document analysis. Transcripts were coded in duplicate using Dedoose, followed by thematic analysis. We find that FCHV union affiliation with trade union federations with male leadership and powerful political connections to parliamentarians has in some cases helped secure increased incentives. Unions have long been demanding formal civil servant status based on reporting and accountability dynamics to health systems, expanded scope of work over time, around-the-clock availability, and lifetime volunteering experience. Following Nepal's transition to federalization in 2015 that transferred FCHV responsibility from the national government to municipalities, unions have secured local 'wins' such as regular monthly allowances and increased retirement incentives, thanks to FCHVs being elected into local leadership, and through female deputy mayors. Securing job formalization remains elusive due to the devaluation of feminized care work and budget challenges. Our findings have implications for

strengthening CHW governance, particularly the participation of health workers – including through their representative organizations – in decision-making around their working conditions.

Gender, Migration, and Registration: The Case of Women Doctors in the UK

Amrita Limbu, University of Leeds, UK

In 2023, the UK saw more doctors with overseas primary medical qualifications joining the workforce than those graduating from UK medical schools. Despite this reliance on international medical graduates (IMGs), the registration process enabling overseas-qualified individuals to practice medicine in the UK remains complex. This presentation explores experiences related to the medical registration process, focusing on the intersection of registration, gender, and migration. Existing research often emphasise migrant professionals' post-registration experiences, career progression, or fitness to practise, with less focus on their registration experiences. While gender disparities faced by women in medicine are well-documented, the experiences of migrant women doctors within the registration framework remain underexplored. This paper addresses this gap by examining the registration journeys of migrant women doctors in the UK, highlighting how regulatory policies centred on patient safety complicate registration pathways, disproportionately impacting women. Employing a gendered perspective, the paper illustrates how migration status and gender intersect, restricting the mobility of this highly skilled group and delaying their return to practise. This reflects broader trends across the Global North, where growing demand for healthcare workers coincides with stringent requirements that Global South professionals encounter in accessing and integrating into the medical profession. Facilitating the registration process enhances the wellbeing of migrant healthcare professionals and supports their access and integration into the workforce, aligning with social medicine principles of equity and justice central to this conference. Drawing on qualitative interviews with migrant/refugee nurses and doctors, this research contributes to discussions on the global movement of healthcare professionals.

Health-less Voice and Voice-less Health: Affective Labor and Techno-Moral Sickness in AI-Driven Korean Call Centers

Kwanwook Kim, Duksung Women's University, South Korea

Since the integration of artificial intelligence (AI) into South Korea's call centre industry in 2018, agents—exemplars of emotional labour—have faced profound

changes. Initially tasked with training AI systems intended to replace them, agents now endure a dual burden. AI, lacking the nuanced “human touch,” generates customer dissatisfaction, leaving human agents to manage complaints through repeated apologies, often enduring verbal abuse for issues they did not cause. Despite these indignities, agents continue to work under precarious conditions characterized by low wages and heavy workloads. Rather than mitigating these challenges, AI has exacerbated job insecurity and heightened agents’ mental and physical health risks. Institutional protections, such as the Industrial Safety and Health Act, remain inadequate in addressing the complex mental distress agents face. Call centre labour extends beyond the commodification of “kindness” to include virtues like “goodness,” compelling agents to endure unjust accusations and unreasonable demands. With AI adoption, the commodification of “goodness” has intensified, transforming it into a product for sale. I term this phenomenon “techno-moral sickness,” describing the suffering of agents as they navigate these dehumanizing conditions. The call centre industry reflects a societal shift where “goodness” is commodified amid a “society of hatred” and “society of anxiety.” In this context, call centres function as “affective sewers,” spaces where negative societal affects converge. This study examines techno-moral sickness anthropologically to propose a framework for recognizing these issues within medical and legal domains, highlighting the broader mental pathologies of contemporary South Korean society.

4E: Participatory modes

Chair: Mayssa Rekhis, University of Gothenburg, Sweden

Megan Clinch and Alison Thomson - Experimenting with transformation: practical imagination, public involvement and equitable health knowledge making

Neymat Chadha - Who leads for health? Understanding the evolution of ‘Communitization’ under India’s National (Rural) Health Mission

Experimenting with transformation: practical imagination, public involvement and equitable health knowledge making

Megan Clinch and Alison Thomson, Queen Mary University of London, UK

A central claim of public involvement in health research is that it will include those who experience inequality and exclusion in the production of more equitable and effective health research and policy. However, building on an ever-growing critical literature on participatory practice, from within and beyond the context of health

research, such aims are often not realized. Based on a study of public involvement in health research in a higher education institution in the United Kingdom, the aim of this paper is twofold. First it will provide further empirical and theoretical insights to understand how and why expansive, equitable and speculative forms of knowledge making are not possible within current health research institutions. Second, building on these insights and drawing on the fields of socially engaged performance and speculative design, we will suggest how health research institutions might redesign their structures and practices of public involvement to support the public and academic actors to collaborate in a more liberatory, prefigurative and generative manner.

Who leads for health? Understanding the evolution of ‘Communitization’ under India’s National (Rural) Health Mission

Neymat Chadha, The George Institute for Global Health, India

Social Participation for Health (SPH), when communities define health priorities and reform, received global endorsement in 2024, with passage of World Health Assembly resolution A77/4. In India, SPH was institutionalized almost two decades prior in 2005 within the National (Rural) Health Mission (N(R)HM) a flagship health reform initiative that called for “communitization.” Twenty years on, we sought to study the evolution of India’s “communitization” to identify lessons for the governance of SPH. We employed an oral history methodology called the Witness Seminar, drawing on the experiences of civil society and government leaders who had been part of developing N(R)HM. Two nationally representative public transcripts were created and analysed inductively. Witnesses shared that India’s ‘communitization’ model included myriad forms based on the experiences and contributions of Civil Society Organizations (CSOs) to N(R)HM. Forms included community member inclusion local decision-making structures (village and facility committees); CSO- supported, community-based monitoring and planning; a national community health worker programme, and devolution of health decision-making to local self-government. With variable government support across Indian states, some forms sustained or expanded, while others failed. A core dilemma as CAH has come of age is balancing the independence and interdependence of its operational (involving interactions between demand and supply side actors), collective (coalition-building and collaboration between and across civil society and communities), and governance (formal and informal leadership) mechanisms. Under “communitization,” of health reform, communities risk becoming mere extensions of the government, leading to challenges of representation, legitimacy, and tokenism in health governance.

Creating and Engaging sessions - Saturday 12.45-13.45

Curating Lifeblood: Edvard Munch and the Medicalization of Modern Life

Allison Morehead, Professor, Queen's University Canada, Canada

Nikita Mathias, Senior Concept Developer MUNCH Oslo, Norway

Phil Loring, Curator, National Medical Museum Oslo, Norway

Like all modern artists, Edvard Munch's life coincided with the rapid changes of modern medicine that shifted major life events such as birth, illness, and death from home to hospital. More significantly, Munch's art, his 'lifeblood', as he called it, often engaged directly and critically with the medicalization of modern life. Paintings such as *On the Operating Table* (1902–3) stem from the artist's lived medical experiences and, as the son and brother of doctors, friend and favoured artist of numerous medical practitioners, his privileged vantage point on medicine. This artwork, like many others by Munch, probes gendered subjectivities amid a healthcare scene, raising questions about clinical medicine and practices of care. I propose to present *Lifeblood - Edvard Munch*, the exhibition I am curating for MUNCH in Oslo, opening 27 June 2025. Intended for the general public, the exhibition juxtaposes Munch's artwork with visual and material cultures of medicine, encouraging visitors to engage with the fact of our vulnerable bodies and the all-too-human efforts to overcome those vulnerabilities through healthcare. I would present key juxtapositions - such as Munch's depiction of a mother with her syphilitic child in proximity to a baby incubator brought from Paris to Rikshospitalet in the early 1890s – and the exhibition's four themes: 1) medicalization: that Munch's work has something to say about our medicalized 'forms of life' (Rose, 2007); 2) universal and particular: that while we all have vulnerable bodies, we undoubtedly have particular experiences of healthcare according to our nationality, gender, race, class, sexuality, and disability; 3) healing and harming: that medicine has the potential to both heal and harm (pharmakon); 4) that care, and in particular intimate body care, is a complex and fraught experience, but one with the potential for remaking the world. My feminist curatorial practice, which I have called 'curatorial medical humanities' (Morehead, 2024), takes seriously the etymological relationship between 'care' and 'curation', among other things centring the voices of sick women (Hedva 2016) and the women caregivers who populated Munch's life and work.

Obesity justice: Reframing the narrative on obesity

Joanna Dobbin, University College London, UK

Rhiannon Osborne, University of Liverpool, UK

This session, including interactive and workshop style elements, will explore the political and community dimensions of obesity, health justice and medical violence. We will discuss multiple dimensions of our obesity health justice work.

1) As health workers, people with lived experience and researchers we will examine the practice of medical violence and weight related stigma. Obesity through the biomedical lens is typically seen as an issue solely of weight, 'BMI' and excess fat deposition. We will explore the harms of this approach and how people experiencing it understand it. We will explore participants' own experience of obesity narratives, practices and treatments in their own life, work and community.

2) We will then explore the political theory which can help us understand this medical violence. We explore the sociopolitical origins of the above narrative, discussing how it is moulded by and serves different political actors, in particular the state and corporate actors. We explore how the biomedical lens also builds on colonial body-ideal paradigms which demonise non-conformant bodies, especially Black women. We present an alternative, ecological framework of understanding, highlighting the neuro-epidemiological evidence that obesity is in fact a complex interplay of hormonal, environmental and social factors and challenging a weight-based definition of obesity.

3) We will present the community-based action that our group has taken. Working with a panel of experts by experience and health care professionals we produced an obesity justice leaflet aimed at acknowledging structural drivers of obesity, supporting people living with obesity, and empowering communities. We have also pioneered micro healing grants for individuals living with obesity, as well as community healing circles, emphasising autonomy, collective care and empowerment as key components of healing.

4) Continuing small group work, we will invite participants to design alternative treatment strategies for obesity using an ecological framework. This could be alternative prevention, monitoring and treatment ideas. We will close the session with reflections and feedback.

Political education for health workers

Nazanin Rassa, University of Bristol, UK

For centuries, the medical profession has invested its trust and social capital into disrupting the structural causes of health inequity. So much so that activism has been termed “the fourth dimension of biomedicine” (Karunatilake, 2022). Today, amidst global crises and health injustice, health workers are increasingly turning to political action. Yet, as intensified policing and stricter sanctions threaten the political imaginations of many, how do we create and sustain spaces in which we can radically reimagine our futures? This session invites the audience to an interactive workshop co-facilitated by students and educators from Bristol Medical School. Our discussion will be grounded within the following: what constitutes political education for health workers? where can health workers currently obtain this? What are the threats these spaces are experiencing and how can these be resisted? Along the way, we will reflect on the work of colleagues and comrades across our collective healing justice lineages as well as the knowledges and practices in the room. Finally, we will bring into question the current omission of political education in traditional medical curricula. If “imagination is one of the spoils of colonialism” (Brown, 2017), then curricula that deny students the space to reimagine their futures serve as tools that sustain the colonial matrix of power. In this space we invite the audience to reimagine and experiment towards alternatives with us: towards infrastructures that protect and sustain our political imaginations as healthcare workers so that we are equipped to continue the fight towards safe and just futures.

Book launch: Medicine on a Larger Scale: Global Histories of Social Medicine

Anne Kveim Lie, University of Oslo, Norway

Jeremy Greene, Johns Hopkins University, USA

In a time marked by rising health inequities and deepening ecological injustice, how can we rethink and revitalize the practices of medicine and public health? We invite you to join us for the launch of a groundbreaking new volume that challenges conventional narratives and opens up new horizons for social medicine.

This collection brings together vivid case studies from Sub-Saharan Africa, South America, Oceania, the Middle East, and Asia—shifting the center of gravity away from a Eurocentric history and toward a truly global, plural understanding. Drawing on a rich tapestry of grassroots movements, community-led health initiatives, and

revolutionary social imaginaries, the book redefines the field of social medicine through a decolonial lens.

Come discuss with two of the book's editors, how social science, state formation, and collective resistance have intersected to shape more just and equitable health systems. As we face urgent global challenges, this book offers not just a broader past, but a deeper well of ideas to draw from in shaping the future of health justice. This book is now available at Cambridge University Press, but also open access through Cambridge Core.

Posters - Saturday 12.45 - 13.45

The Psychiatric Healthcare Crisis in Egypt: A Socio-Medical Perspective on Access and Misguided Alternatives

Hamed Ahmed, Egyptian Fellowship of Neurology, Egypt

In Egypt, there is a significant shortage of medical professionals within the psychiatric healthcare system, which severely limits access to essential mental health services. The lack of adequate training in psychiatric first aid, especially in primary healthcare settings, and insufficient psychiatric nursing staff exacerbate the issue. As a result, Egyptians spend approximately 50 billion EGP annually on non-medical practitioners, such as soothsayers and charlatans, for mental health-related issues. Due to this situation, Egypt suffers from a severe shortage of psychiatrists, with only about 1% of the total 250,000 doctors being psychiatrists, amounting to fewer than 1,000 psychiatrists for a population of over 100 million people, in stark contrast to approximately 300,000 soothsayers and charlatans. Official statistics reveal that 25% of the population suffers from mental health conditions, and of those, 50% are also struggling with substance abuse disorders. This widespread addiction crisis places a heavy economic burden on the country and hampers the potential for effective mental health treatment. This study explores the critical gaps in psychiatric healthcare, with a focus on the under trained workforce, and evaluates the societal and economic consequences of this issue. The findings highlight the need for targeted interventions to build a more qualified psychiatric workforce, improve mental health education, and reduce reliance on non-medical solutions. By addressing these systemic issues, the research aims to promote the development of a sustainable mental health infrastructure in Egypt, reduce the burden of addiction, and improve public health outcomes.

Bridging the Gap: Improving Health Economics and Social Medicine Education in German Medical Training

Christine Holmberg, Brandenburg Medical School Theodor Fontane, Germany

In light of demographic changes and the resulting increase in demand for social and healthcare services, future physicians are confronted not only with the challenge of providing medical care to their patients but also with questions about sustainable and equitable resource allocation within the healthcare system. In this context, the fields of "Health Economics" and "Social Medicine" are becoming increasingly significant. This growing importance was reflected in the 2002 revision of the German Medical Licensing Regulations (Approbationsordnung), which formally integrated these subjects into medical education. Universities, however, retain the flexibility to independently design and implement the content of these courses. Despite the relevance of this subject area, there remains a lack of scientific analysis of the teaching practices in this field within Germany. To address this gap, we conducted a survey of educators and early-career physicians in Germany to assess the current state of teaching with the aim of developing a curriculum that ensures both content and structural consistency in education. The survey of educators revealed significant variation in the teaching content, the methods of implementation and the involvement of different disciplines. Conversely, the survey of early-career physicians indicated that 60% retrospectively perceived the teaching as insufficient, while 79% felt it inadequately prepared them for professional practice. This stands in contrast to the perceived relevance of the content itself, which 66% of respondents – 29% of whom rated it as very relevant – considered important from a contemporary medical perspective. Key suggestions for improvement included calls for more comprehensive and higher-quality teaching, with a greater emphasis on practical application.

The Socmed Database: A clinical database with hospital record data from patients seen in The Social Medicine department of the Capital region of Denmark

Mia Button, Department of Social Medicine, Copenhagen University, Denmark

We aim to describe the contents of the SocMed Database, including completeness and representativeness. Furthermore, to describe the characteristics of the population in alignment with the bio-psycho-social model and examine the perspective of physician and patient in relation to expected labour. A RedCap survey was used for data entry. Data was gathered from January 2014 to December 2022,

and data was validated through comparison with patient charts and the Danish National Patient Register (DNPR). The study population consisted of 6,208 individuals. 28.6% individuals entered in the database were not found in DNPR. The analysis revealed that the majority of individuals in the database were aged between 40-59 years (71%) and predominantly female (57%). Most patients were on cash benefits (80%) and exhibited high rates of psychiatric and musculoskeletal disorders, with multimorbidity prevalent. The findings also indicated significant issues with functioning, housing, and adverse life events, with 94% of charts documenting adverse experiences. Patient and physician perspectives on labour market outcomes showed a consensus, with about 60% of patients and 55% of physicians not expecting a return to work. The SocMed Database provides a unique and comprehensive view of a vulnerable population that is often excluded from the labour market due to health issues. By incorporating a wide range of biopsychosocial variables, the database facilitates future research into the connections between these factors functioning thereby contributing to the development of targeted interventions and policies aimed at improving the lives of affected individuals.

Healthcare and migration

Megan Carney, University of Arizona, USA

Moving abroad is an increasingly trending topic in the United States. Previous research has documented the ways that economic opportunities, political climate, and personal reasons frequently inform decisions to leave. However, less attention has been given to the role of safety and healthcare as these shape desires to relocate abroad. This paper presents findings from a recent study on US emigration that included qualitative interviews (n=60) and a large cross-sectional survey (n=550) in which participants stressed concerns about safety and healthcare in pursuing futures outside of the U.S. Engaging with theory from critical medical anthropology, Black feminism, and critical mobility and circularity studies, this paper analyses how emigration itself emerges as a site of care that gestures to the perverse logics and outcomes of neoliberal governance in individualizing responsibility for health and wellbeing.

“Don’t Rock the Boat:” From Professional Identity Formation to Social Reproduction in Medical Education

Hannah Connolly, University of California Los Angeles, USA

To enter into a profession is to take on a new identity, and literature around professional identity formation (PIF) has taken off in medical education (Sarraf-Yazdi et al., 2021). However, the PIF literature has been characterized as interventional rather than exploratory, with little attention to PIF as a socialization process (Sarikhani et al., 2022). Drawing upon a year-long ethnographic study with third-year medical students in the Northeastern United States, I identify “don’t rock the boat” as a guiding principle of medical students’ PIF. Subsequently, I offer an analytical turn from PIF towards social reproduction. I find that students utilize practices like not reporting problematic behaviours or systemic injustices in their learning environment to avoid “ruffling feathers,” to secure good evaluations from their preceptors. I also describe how the students acknowledge they are playing the “game” of medical education and articulate that speaking up against the status quo is inherently unsafe for medical students. The medical students communicate their regrets about this, but despite their best intentions, they resign themselves to the game. Therefore, I argue the framework of social reproduction reveals the professed professional value of social justice in medicine is incompatible with the professional dispositions of passivity and individuality inculcated in the medical student habitus. I argue that utilizing the framework of social reproduction highlights the critical need to adopt counter-training as a guiding principle in curricular development to cultivate an alternative medical student habitus that aligns with social justice efforts.

“Everything at Once”: Exploring Interactions, Relationships, and Networks Among Doulas of Colour in Los Angeles

Nada Dalati, University of Southern California, USA

This project explores the social dynamics between and among doulas of colour in the Los Angeles area. I focus primarily on organizations and collectives that offer doula services as well as opportunities for doulas themselves - namely the AAIMM (African American Infant and Maternal Mortality Prevention Initiative) Doula Program and Frontline Doulas, as sites and facilitators of these nuanced interactions. Such opportunities for interactions come in the form of trainings, which are vindications vehicles for the passing of generational knowledge on reproductive care work from one doula to the next. True community building and networking, as I will demonstrate, occurs shortly after trainings in the form of mentorship, where doulas process births with the psychosocial support of their cohorts and more experienced

doulas of colour. Ultimately, I seek to illustrate the plethora of ways that knowledge and placemaking are utilized by doulas to create self-reliant concentric communities for women of colour and doulas of colour alike.

Cartographies of Care: Reimagining Health and Therapeutic Landscapes for Young Women in Freetown Sierra Leone

Sadia Demby, University of California San Francisco, USA

My research, conducted between 2020-2022, studies the healthcare landscape for young women in Freetown, Sierra Leone to deepen the scope with which we see and represent care delivery in the region. Sierra Leone is often depicted through images of war, diamonds, and haemorrhagic fever. However, what is overlooked in these narratives of conflict/sickness is the experience of those living and healing over this country's course. Building on urban theory and medical anthropology, I trace Freetown's clinical landscape from the 18th century to the present day to demonstrate how the colonial-biomedical infrastructure that undergirds Freetown's contemporary health system necessitated the emergence of alternative spaces and pathways, both within and outside of formal health infrastructure, to meet the needs of those on the margins of society. I developed the historically grounded, multimodal, (non)clinical term of "individualized networks of care" to explore the social and physical infrastructures women access to push back against these harmful legacies and fulfil their holistic health needs. Grounded in ethnographic fieldwork in the east end of Freetown, this research is among the first anthropological studies of care that begins with women's worldviews and self-imagined solutions to represent a health system, introducing a novel approach to how we study systems and cultures of caregiving. It also draws attention to the importance of women's creative solutions to building an asset-based, care-centric health system in Sierra Leone.

Theorizing access to healthcare: an arena for negotiating eligibility

Michael Fehsenheld, Aarhus University, Denmark

Access to healthcare is a driving mechanism of inequity in health. Inequitable access occurs when access varies according to personal and social attributes rather than the need for care. For many people with severe mental health issues, social and health problems are inextricably connected, as are the needs for care. Previously, access to care was viewed as a functional attribute of health services, ensuring that services can be accessed or utilized by those requiring care. Today, much of health service literature conceptualize access from a systemic perspective, including structural

features of the health care system (e.g., availability, affordability, etc.) and features of individuals (predisposing and enabling factors). In this paper, we propose to expand conceptualization of access with a constructivist perspective. Building on one year of interviews and observations of interactions between health care professionals and people with mental illness, we explore how access is an arena for negotiating eligibility. These negotiations draw on categorizations from the policy level (e.g., the definition of the target group) and institutional norms (e.g., professional understandings), and individual perceptions of eligibility. We show how access is obtained through hard work of the users negotiating their eligibility. Analytically, we apply the concept of ‘Candidacy’, arguing that this conceptual lens can enhance the anthropological analysis of the social processes of constructing access to care. Candidacy adds to the understanding of access highlighting the interrelated processes at policy, institutional, and micro level, which determine who is eligible for care and when.

Crisis and Care: Transforming U.S. Mental Health Systems Through Equity and Innovation

Jeremy Fine, Gillings Schools of Global Public Health, University of North Carolina, USA

U.S. mental health systems have been chronically underfunded, historically resulting in the institutionalization and impoverishment of some of society's most vulnerable individuals: those with severe mental illness. While significant progress has been made over the last century, numerous challenges persist. High demand for psychiatric care, shortages of inpatient beds, and prolonged emergency department boarding times continue to strain the system's ability to provide timely and effective care. In many regions, reliance on involuntary treatment and law enforcement-based crisis responses further marginalizes individuals in crisis and exacerbates trauma associated with psychiatric treatment. The state of North Carolina serves as a case study for these systemic issues. This state highlights the need for theoretical guidance and actionable strategies that prioritize accessibility, equity, and care in the least restrictive setting. Building on this context, the presentation introduces the Substance Abuse and Mental Health Services Administration (SAMHSA) crisis care framework as a roadmap for addressing these challenges. Our team utilizes participatory systems science techniques, including system dynamics simulation modelling, group model building, and structured stakeholder interviews, to apply SAMHSA's principles in real-world settings. By simulating patient flows and resource allocation, these methods empirically identify barriers and inform solutions to optimize crisis systems. Case studies from Michigan and Illinois illustrate how these

approaches reduce reliance on coercive practices, improve care coordination, and address critical capacity gaps.

People on long-term sickness absence and their experiences and perceptions of professionals from the vocational and the health care sector – In this together?

Christian Patrick Jauernik, University of Copenhagen, Denmark

People on long-term sickness absence in Denmark experience the help and support they receive from professionals as problematic. To understand these issues, this study, through interviews of eight interlocutors, investigated how people on long-term sickness absence perceive and experience professionals from both the vocational and health care sector involved in their situation. Our study led to two main findings: Firstly, the roles of professionals often transcended their formal boundaries, with caseworkers frequently becoming involved in the sick absentees' health-related issues, and health care professionals frequently becoming involved in the sick absentees' vocational issues. Secondly, professionals from both sectors were perceived as enacting one of two positions: A 'position of togetherness', where professionals were perceived as someone helping the sick absentee in managing their situation, and a 'position of otherness', where the professionals were perceived as an additional uncertainty of the sick absentee's situation. These positions were situational and could change depending on the context and through time. The research highlights the importance of meaningful relationships between professionals and sick absentees, suggesting that fostering a position of togetherness can lead to better outcomes. We believe our findings can help professionals better understand and support people on sickness absence.

‘Oh, for the good old pre-organizational days’: Lessons on professional identity from the formation of the American Art Therapy Association

Adam Ludwig, University of Southern California, USA

Uniting art history and the history of medicine, this presentation draws on a project which examines the professionalisation of art therapy in the United States during the twentieth century. Its fulcrum is the 1960s, with the establishment of the nation's first long-running graduate program in art therapy at Hahnemann Medical College in Philadelphia in 1967, as well as that of the American Art Therapy Association in 1969. The emergence of these institutions, both propelled by art therapist Myra Levick, was met with hostility. Many art therapists felt that Levick and her psychiatrist colleagues wished to confine art therapy to the position of an “ancillary psychiatric discipline,”

one which reduced their autonomy and placed predominantly female art therapists under the supervision of predominantly male doctors. Art therapy had been practiced extra-institutionally for centuries, yet it was only the humanist fervour of the 1960s and the coincident ascent of American psychiatry that provided a sudden opportunity for art therapy to become institutional, with the promise of salaried clinical and faculty positions. Practitioners of art therapy felt independence positioned against stability. The debates that ensued regarding standardization of care and the gendered consequences of hierarchy gesture at questions that are central in all clinical professions. Historiographical, this project urges the history and practice of medicine to approach the clinic as a social field where patients and providers are always working within discursive limits. The history of art therapy presents a forum for understanding how professional identities and physical media meld those limits together.

Bridging Anthropological and Biomedical Perspectives in Health Professions Education: From Theory to Action and Practice

Iveris L. Martinez, PhD, California State University, Long Beach, USA

Chelsea Wentworth, Michigan State University, USA

For decades, anthropologists have found it challenging to integrate anthropological theory and knowledge in ways that are tangible, practical, and complementary to the health sciences. In order to have a broader impact in the health sciences, we must first understand the “entrenched epistemologies” of biomedical perspectives and training, and how it compares to anthropological perspectives. Our epistemological frameworks are fundamentally different, with the biomedical sciences adopting a primarily positivist perspective, while anthropologists are oriented towards a constructivist/interpretive approach to knowing. These divergent perspectives when approaching the health of patients and populations across various domains pertaining to diagnosis and care of health concerns need to be acknowledged and understood if we are to effectively integrate social theory in action and practice more broadly through health professions education. By fostering critical thinking and collaboration we can construct joint approaches to health and address current health challenges. In this session, the goal is to foster a discussion of these divergent epistemological approaches to health education and provide examples of how they can be bridged to advance the practice of social medicine. First, we posit the question of how health is understood and approached. Second, we must consider what constitutes evidence and how is evidence analyzed and what is the unit of analysis. Third, we need to consider how health science students approach learning and develop creative ways to translate and distill anthropological

knowledge, including critical analysis of power and social dynamics that impact patient and population health, for every day clinical application.

Hemodialysis Patients in War Zones: Health Outcomes and Challenges in Gaza

Farah Miqdad, Faculty of Medicine, Al-Quds University, Abu Deis, Al-Azhar University, Palestine

Farah Miqdad, Amro Hamada¹, Baraa Alhendawi¹, Yara Taweel²

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The ongoing war in Gaza has decimated healthcare systems. Our cross-sectional study included 292 hemodialysis patients from four hospitals: Al-Shifa (60), Al-Aqsa Martyrs Hospital (116), Al-Zawaida Field Hospital (13), and Nasser Medical Complex (103). Data were collected through structured interviews using a digital questionnaire, covering demographics, laboratory results, war-related challenges, dietary habits, and quality of life (WHOQOL-BREF). Descriptive and inferential statistical analyses were performed in R. Among the participants (51.4% male, mean age: 47.8 ± 16.1 years), a Wilcoxon signed-rank test revealed a significant increase in canned food consumption during the war, with 70.55% relying on it as a primary nutrition source ($p < 2.2e-16$). A negative binomial regression showed a significant positive association between hemoglobin levels and displacement count ($\beta = 0.0774$, $p = 0.00132$), indicating that individuals with higher hemoglobin levels experienced more displacements. Hemoglobin levels varied significantly across hospital sites (Figure 1), with notable differences between Al-Aqsa Martyrs Hospital (A) and both Nasser Medical Complex (N) and Al-Shifa Hospital (S) ($p = 0.0075$), but no significant difference between Al-Aqsa (A) and Al-Zawaida Field Hospital (Z) ($p = 0.2316$), likely due to the transfer of dialysis patients from Al-Aqsa to Al-Zawaida. The mean physical quality of life score was 37.6, and a Wilcoxon rank sum test demonstrated a significant difference in physical quality of life between wheelchair users and non-users ($p = 0.001441$), underscoring the impact of mobility status on well-being. These findings highlight the profound effects of war on the health of hemodialysis patients in Gaza.

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Nongovernmental organizations as relevant stakeholders in the facilitation of work (re)integration following a chronic illness diagnosis in Romania

Adela Elena Popa, Lucian Blaga University of Sibiu, Romania

Chronic diseases in the working-age population produce considerable impairment in work participation. A considerable proportion of the persons with chronic conditions continue to work during treatment or return to work after sick leave.

Nongovernmental organizations (NGOs) can potentially influence the work (re)integration process alongside other stakeholders, yet their role has not been studied so far in the Romanian context. Building on the Person-Environment Fit theory, we collected data through semi-structured interviews with 11 officials of Romanian NGOs active in fields relevant to this topic. Thematic analysis was employed to emphasise the main topics in their discourses. The poster will present results on how representatives of Romanian NGOs view their actual and potential role in work integration and return to work following chronic illness, their perspectives on the factors that can be barriers and facilitators, and the collaboration with other stakeholders (employers and health professionals). The preliminary results show a relatively informal and irregular involvement of NGOs in the work (re)integration of workers with chronic illnesses and the lack of a policy framework. The study is relevant for countries with a similar type of involvement of NGOs in work reintegration facilitation, such as the Central and Eastern European countries.

Immigrants to health: negotiating liminality and belonging with cystic fibrosis

Stefan Reinsch, Brandenburg Medical School, Germany

Medical anthropologists and sociologists have long studied how people with a disease or disability cultivate embodied knowledge and situate themselves within their socio-cultural context. More recently, research has focused on how people's embodied experience affects how they come to understand themselves - their selfhood and identification - in the midst of therapeutic innovation and development. Drawing on a long-term ethnographic study of cystic fibrosis, a rare genetic disease that significantly reduces life expectancy, I explore how people with a rare disease and their care team negotiate therapy and identity. CF therapy can delay the progression of the disease, but it is burdensome, time-consuming and makes the disease more visible, creating a sense of not belonging to the healthy peer group that young people desperately want. Recent, very expensive advances in therapeutic interventions have dramatically reduced both the amount of therapeutic and the visibility of the disease. I propose the concept of 'immigrants to health' to intervene

in the theory and practice of care research in CF and rare diseases more generally. The concept allows for a different way of understanding the self beyond the traditional biomedical narrative of cure or decline; and it sheds new light on debates in medical anthropology and social medicine about how the experience of illness and disability transforms sociality through the construction of individual and group identities around it.

Broader impacts of the hidden curriculum: Analyzing individual responsibility discourse in maternal and child healthcare in Vanuatu

Chelsea Wentworth, Michigan State University, USA

Frequently health care workers around the globe are trained in traditions of Western biomedicine that emphasize neoliberal ideas of personal responsibility for achieving and maintaining health. This mindset is often communicated through the hidden curriculum, when students are socialized in the culture of Western biomedicine. We analyze how biomedical health care providers use affective health care encounters at maternal and child health clinics in the South Pacific Island nation of Vanuatu to reinforce emotional labels of “good” and “lazy” mothers based on mothers’ abilities to enact health and nutrition advice provided in clinical care—a place we see the hidden curriculum reproduced in patient-provider interactions. We present a series of ethnographic vignettes illustrating how ubiquitous healthy eating messages are infused with affective ideologies, reinforcing the idea that by providing healthy food, a mother is properly caring for her children. However, a mother’s ability to achieve these recommendations relies on factors beyond her control, including structural violence and persistent poverty. Through the analysis of moral discourse during well-baby visits, our data show how neoliberal ideology of individual responsibility permeate health care exchanges, despite cultural ideology that prioritizes community well-being. Applying critical friendship, ethnography and decolonial feminism to theorize new pathways toward healing. We call for changes to health professions education that improve patient-provider communication to limit the reproduction of harmful neoliberal discourse on personal responsibility, ultimately improving health outcomes and health equity.

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Our aim is to gather a network of health practitioners jointly trained in or working in the health professions and the social sciences or humanities. The humanities and social sciences provide frameworks for questioning, analyzing, and theorizing issues affecting societies, health, and wellbeing today. Health professionals trained in the humanities and social sciences may have unique perspectives on these questions in their own fields. Fostering interdisciplinary collaboration is vital for addressing contemporary health challenges, in Norway, Europe and further abroad.

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