Hermeneutical injustice in global health

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Summary

Many injustices in global health have been described in recent literature. Most authors analyse these issues from a distributive paradigm. The distributive paradigm, however, has been criticized to fall short of identifying important relational and structural injustices in global health. This thesis contributes to advancing our understanding of relational global health injustice by arguing there is hermeneutical global health injustice between the Global North[1] and the Global South[1]. Miranda Fricker describes hermeneutical injustice as a gap in hermeneutical resources between the speaker and the hearer, which disables the speaker to interpret and make sense of his or her social experiences (2007). Most analyses discuss *local* hermeneutical injustice. To illustrate how it is also present *globally* and specifically in *global* health, I will provide two examples: paternalism in and the medicalization of global health. Moreover, I will, as a justification for pursuing hermeneutical justice, argue for an ecumenical account of duties from justice that appeals to both cosmopolitans and social liberals. Finally, having outlined the problem and moral basis for the obligation to remedy hermeneutical injustice in global health, I will critically examine Fricker's normative account of the virtue of hermeneutical justice and advocate for a participatory approach instead.

Keywords: global health, hermeneutical injustice, epistemic injustice, virtue ethics, participation, participatory parity, relational paradigm, structural inequality

[1] The reason for choosing these terms will be explained in chapter one.

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Introduction

The timing of the call for justice in global health could not have been better, as the world is experiencing a global pandemic. Unlike many other global health issues, the Global North is disproportionally affected by the new coronavirus. Although the pandemic has caused many deaths in Europe and the United States of America, it also shows major health disparities between the Global North and the Global South when it comes down to the number of resources that each can spend on fighting the pandemic.

Officially, the number of people that is infected with the new coronavirus in the Global South is relatively low. Statistics performed by the World Health Organization (WHO) showed that at the beginning of June 2020 Africa was confronted with approximately 18 times less infected patients than Europe (WHO, 2020). But the fear of an outbreak and the consequences of the lockdown that many countries announced are being experienced. Some countries, like the Central African Republic, do not even possess ventilators would they be needed to help a covid-19 infected patient (Vos, 2020). Moreover, in March, African doctors feared that the focus on the new coronavirus would shift away from other infectious diseases that still cause many deaths, such as malaria, tuberculosis and AIDS (Schenkel, 2020). In April, it indeed turned out that approximately 500 thousand more people died of AIDS in Africa, compared to 'regular' periods, since due to the lockdown patients are not able to receive their medication (NOS, 2020). As the total amount of people that died from covid-19 at the start of June was almost 400 thousand globally (WHO, 2020), it needs no further explanation that we face huge global health disparities – or even injustices. The covid-19 pandemic is just another painful revelation.

This thesis will focus on global health injustices and more particularly global *hermeneutical injustice*. Hermeneutical injustice was first described by Miranda Fricker, who describes it as a gap in hermeneutical resources between the speaker and the hearer, which disables the speaker to interpret and make sense of his or her social experiences (2007). Hermeneutical injustice originates in (1) unequal hermeneutical participation of the speaker in a conversation, which together with (2) a background situation of structural inequality and (3) structural prejudice against the group to which the speaker belongs, leads to a situation of hermeneutical injustice. To the best of my knowledge, a precise description of these three criteria that distinguish epistemic isolation and epistemic bad luck from a hermeneutically unjust situation has not been given clearly in the literature. So, this will be my contribution to the debate. Moreover, the link between hermeneutical

injustice, as explained by Fricker, and structural inequality, a concept described by Young (2009), has not been explored elaborately. Also, most literature on hermeneutical injustice focuses on the local context, and to the best of my knowledge, this thesis will be the first application of the concept on a global scale and particularly to global health. Finally, I will critically analyse Fricker's normative answer to hermeneutical injustice, which is, among other things, too focused on the individual hearer and provide, to the best of my knowledge, an underexplored and more sufficient answer to hermeneutical injustice in global health: a participatory approach.

The global (health) justice debate has mostly taken place in the distributive paradigm. That is to say, most questions on global justice have been about who, to whom and how we should distribute which resources to reach global justice. This has been criticized by authors from the *relational* paradigm – relational egalitarians – who argue that the distributive paradigm cannot account for aspects such as status, stigma, respect and recognition. These factors, that concern the way we relate to one another, are, they argue, overlooked by the focus on the distribution of resources. An equal status, for example, cannot be reached by providing everyone with the same number of resources, if there are still *structural* inequalities that generate advantage to the members of one group and disadvantage to those from a different group, for example, women, disabled people and other minorities. To be able to analyse these inequalities, we have to make a group-based analysis, rather than focusing on individuals. Only then we can see the structural inequalities, inequalities that are "relationally constituted through interactions that make categorical distinctions among people in a hierarchy of status or privilege" (Young, 2009, p. 363). These inequalities are group-based injustices because they disable individuals from specific groups to have equal opportunity in society. These injustices cannot, according to relational egalitarians, be met by a redistribution of resources but ask for an analysis focused on relational aspects.

I will, thus, contribute to the global health debate by arguing for the presence of hermeneutical injustice in global health between the Global North[2] and the Global South[2], which can be analysed from the relational paradigm as it has both relational and structural elements to it. Of course, I will explain that the debate on hermeneutical injustice also includes distributive matters, since hermeneutical resources can and should be distributed, but this will not be the focus of my thesis.

[2] Again, the reason for choosing these terms will be explained in chapter one.

My argument will be structured as follows. In the first chapter, I will investigate the global health debate. I will focus specifically on the moral importance of health in global justice debates, provide a definition of individual and global health and give an overview of what distributive global (health) justice theories are described in the literature, based on what types of duties and what duty-bearers are distinguished. I will lay the foundation of an ecumenical account of duties from justice, which appeals to both cosmopolitans and social liberals arguing for corrective injustice. This foundation will be explored more in chapter two, where I will show how hermeneutical injustice can be considered – partly – a corrective injustice and therefore appeal to the account of social liberals. Chapter one will finish with describing the critique and insights of relational egalitarians, to show how this paradigm can add to the discussion on global health justice and give rise to the analysis of hermeneutical injustice from this paradigm.

The second chapter will be focused on the concept of hermeneutical injustice and its relation to structural inequality in general and in global health. Therefore, I will describe Fricker's explanation of hermeneutical injustice (2007) and Young's analysis of structural inequality (2009) and investigate their relationship. Finally, this chapter will contain several semi-empirical examples of how hermeneutical injustice in global health actually takes place: namely in paternalism in and the medicalization of global health.

In the last chapter, I will critically investigate the virtue of hermeneutical justice, proposed by Miranda Fricker, and its function in global health. As this account turns out to yield several issues, especially when applied to hermeneutical injustice in public health on a global scale, I will advocate for a participatory approach. I will again use the examples set out in the second chapter to show how my account is better able to deal with the issues of hermeneutical injustice in global health, because it can provide equal hermeneutical participation.

1. The global health debate

In this chapter, I will construe the global health debate: what the concept of (global) health entails and what global (health) injustices and duties are described in the literature, both by distributive theorists and relational egalitarians. This will help the analysis of the concept of hermeneutical injustice (see chapter two) in global health.

In this thesis, I will use the terms Global North and Global South instead of 'first-world' and 'third-world' or 'developed' and 'developing' countries – even if the latter terms are used by the authors I am discussing (except for direct citations, of course). As these latter terms have become obsolete, most prominent organizations now use the Global North-South divide (OECD-UNDESA, 2013) to distinguish countries according to their rate of development (which is already a debatable concept in general, but which falls outside the scope of this thesis). There is no explicit classification which countries belong to the Global North and South but an analysis of several social science studies showed that most authors associate Europe, North America and Japan with the Global North, while Global South regions were considered Asia, Africa, Latin America and the Middle East (Pagel, Ranke, Hempel & Köhler, 2014). Since the terms are more or less social constructs that were created after the end of the Cold War rather than realistic definitions of what characterizes 'development', I am aware of the pitfalls of using them. For example, the distinction is geographically unprecise, since most countries of the Global South are in the Northern Hemisphere and since various cities in the Global North share characteristics with countries in the Global South and vice versa (Caison & Vormann, 2014). So, while being aware of the subjectivity, sensitivity and incompleteness of the terms, I will use Global North and Global South in the remaining of this thesis meaning the regions that were mentioned before. Whenever relevant in specific sections, I will again emphasize the wariness that should be kept in mind when interpreting conclusions about the Global North-South divide.

1.1 The concept of (global) health

Before diving into the global health debate, this section will describe the concept of health in general and more particularly of global health. Deciding on the moral importance of health and giving a definition of (global) health will later help to place the concept of hermeneutical injustice (see chapter two) in the global health debate.

1.1.1 The moral importance of health

How should we value health? Empirically speaking, researchers have found that health is one of the determinants of well-being, and in some regions, like North- and South America even the most important factor (Sustainable Development Solutions Network, 2020). Philosophically speaking, there is much more discussion on the value of health, and it is not my aim to dive into this complex debate. What I will do, though, is explain how (distributive) theories of justice generally think about health, to show how it is of importance to most of them, using Daniels' argument (2012). This will support my point of view that any injustice in health needs attention, which also applies to hermeneutical injustice, a concept I will explain in the next chapter.

Daniels (2012), in his book Just Health, has set out his argument why health is of specific moral importance in various theories of justice. First, he starts by showing how in a Rawlsian theory of justice fair equality of opportunity leads to special moral importance for health, since "meeting health needs promotes health, and since health helps to protect opportunity, then meeting health needs protects opportunity" (2012, p. 30). Later in his argument, he shows how other distributive theorists, who similarly use the idea of equality of opportunity, must also agree on the instrumental value of health. While health *care* has been a major focus of distributive theories, Daniels (2012) shows that since health care is only one of the social determinants of health, theories of justice should also focus on other factors that influence health. This view matches my definition of global health, as we will see in section 1.1.3, in which attention is devoted to several economic and social determinants of health.

For most theories of justice, health has at least instrumental value, as it contributes to protecting equal opportunity (Daniels, 2012), or for example because it enters into utility (Fucks & Zeckhauser, 1987). In other words, health is a means to participate in life, in society. Others have argued that health has intrinsic value, meaning that health itself is valuable and not only for providing equal opportunity. This is for example argued for by Downie et al., as explained by Duncan (2010), stating that health is intrinsic to human flourishing. Their position can be considered quite harsh: if health is genuinely intrinsic to life, a sick individual might be regarded as 'inhuman'.

Other bases for the moral importance of health are given by those arguing for a capability approach. For example, Sen and Nussbaum, as explained by Law and Widdows (2008) argue that because people are different, approaches that try to make a list of basic needs, such as a Rawlsian

theory of primary goods, fail to take into account 'basic capabilities': what people are able to do and be in life. Since people are different, there is no such basic list of needs that is similar for everyone. So, a capability approach "allows for a 'basket' of health goods which changes between contexts and individuals", some global, some local and some individual (Law & Widdows, 2008, p. 17). Therefore, Law and Widdows have argued it could be more applicable to *global* health (2008).

Although this could indeed be useful for my thesis, I do not necessarily have to choose an account on which I base the moral importance of health. Rather, I wanted to show that either way, on most theories of justice, health has at least *some* moral importance. I will not extend the list of theories that have a different explanation for the moral importance of health to choose one that is 'best'. Rather, having set out the moral importance of health, I will use the next section to formulate a definition of individual and global health which will be used as a background for the rest of my thesis. Moreover, section 1.2 will be devoted to describing important distributive theories of justice and whether and what type of duties we have towards others in distributing health.

1.1.2 Defining individual health

A central issue of (bio)medical ethics is the definition of 'health' and 'disease', in which there seems to be little consensus. It raises the question if we can and should even try to define health at all (Callahan, 1973). Although I am aware that any given definition of health yields problems, I am still convinced that defining health can help to guide the rest of this thesis. Therefore, I will describe the major trends shortly, and choose the account that is, in my opinion, the least problematic and most useful for the global health debate.

Ereshefsky describes three major lines of argumentation in defining health: the naturalist, normativist and hybrid approach (2009). First, naturalists fall back on biology to determine what disease and health are: purely physiological or psychological states of being, without reference to how we value them. An important counterargument to this is that biology (such as taxonomy and genetics) is not able to tell us which traits or genes are normal and thus healthy – and which traits are not. On the contrary, variation in traits and genes has evolutionary preference over 'normality' as it serves the survival of the fittest (Ereshefsky, 2009). Moreover, and in my opinion an even stronger counterargument given by Ereshefsky, is that purely naturalistic accounts seem to confuse as they do not take into account how our *values* change the way we think about health and disease.

For example, previously, people with mental health diseases were stigmatized and therefore recognition of these diseases has taken quite some time. Societal change can thus change the way we look at health and disease, which is not accounted for in naturalistic accounts.

This has also been argued by normativists. They claim that the way we value health and disease depends on what we see as health and what not and that there is no objective, scientific meaning of health (SEP, 2008). So, every definition we give of health will be value-laden, meaning that which states are considered healthy, and which are not, depends on the value of these states, which can differ through cultures and times. Disease, then, is the abnormal state from a shared, culture-specific conception of human nature (SEP, 2008). However, as Ereshefsky (2009) clearly explains: the flaw of naturalism is also present in normativism, namely that defining health and disease *only* by referring to values seems to miss out on the complexity of the issue. It seems plausible that not everyone is naturally motivated to be healthy as they might value health differently and inferiorly to other values, such as well-being. Therefore, in my opinion, normativism runs the risk of collapsing into relativism, meaning that everyone has a different idea of what health is, which complicates making health policies and also runs the risk of being paternalistic (e.g. 'it is bad for you to be that way') (SEP, 2008). As the pure naturalist and normativist accounts thus yield issues, it seems that a compromise between the two is best.

Therefore, the most appealing account seems to be a hybrid account, in which a certain state is said to be a disease when it is both dysfunctional and disvalued (Ereshefsky, 2009). The definition of health giving by the WHO seems to be a hybrid one, where health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (2020, p.1). This definition provides space for cultural values – e.g. the meaning of social well-being can vary in different regions – but still takes into account naturalistic aspects, since it points out the importance of physical well-being as being more than, but at least including, the absence of disease or infirmity. Although one can still question hybrid accounts, I will take on this view, since it is especially relevant for this thesis to avoid the problems of pure naturalist and normative accounts. Namely, a pure naturalist account, in my opinion, runs the risk of the medicalization of certain states that might not be considered a disease. Kaczmarek (2018) has also argued that extension of official classification of diseases, such as the DSM-IV is an example of medicalization by purely biomedical or naturalist approaches. Medicalization in global health, as I will explain later, is exactly the situation of hermeneutical injustice that we have to fight.

Another problem arises in a pure normativist account, which I have mentioned risks being paternalistic, by judging for other people what is bad for them. Paternalism in global health, again, is a situation of hermeneutical injustice that should be remedied. In my view, the WHO definition can tackle these issues, so it seems the best settlement for a definition of individual health. Unfortunately, I will show in the next section that for application on a *global* scale it seems to miss important elements. Therefore, I will use the next section to elaborate on a more suitable definition for global health.

1.1.3 Defining global health

What are these problems that make the WHO definition of health difficult to apply on a global scale? First, it has been criticized for being utopic (Kaczmarek, 2018). As the organization admits itself: the Global South's weak health systems and poor preparedness for health emergencies are for many individuals major obstacles to reach a complete state of health (WHO, 2018). Second, the definition has been said to turn everything into a 'health' problem, again an issue of medicalization, while for example in several parts of the world lack of social well-being can be easily caused for reasons other than health problems, such as crime or war (Callahan, 1973). But the most important counterargument, for my thesis, is that for a proper definition of *global* health, the focus needs to shift from individual aspects only to the inclusion of the *structural* elements that play a major role in global health. Therefore, I will follow Benatar and Upshur's interpretation of global health, in which useful parts of the WHO definition are taken into account but with more attention to the effect that structural elements have. They namely argue that a definition should take into account "the interconnectedness of all people and all life on a threatened planet". Therefore, it should be distinguished from international health in which the primary attention is on states rather than on individuals (SEP, 2015). Benatar and Upshur define global health thus as follows (2011, p. 14):

> Global health is the science and art of preventing disease, prolonging life and promoting physical and mental health through organized global efforts for the maintenance of a safe environment, the control of communicable disease, the education of individuals and whole populations in principles of personal hygiene and safe living habits, the organization of health care services for the early diagnosis, prevention and treatment of disease, *and attention to the societal, cultural and economic determinants of health* [emphasis added]

> that could ensure a standard of living and education for all that is adequate for the achievement and maintenance of good health.

Besides including *structural* elements, the definition also focuses on social and cultural determinants that decide how we *relate* to each other. The inclusion of these elements is important for an analysis of global health justice from the relational paradigm, as I will explain in section 1.2.2. But first, I will describe the major global (health) justice theories that argue from a distributive paradigm.

1.2 Global health injustices and duties

This section will be devoted to the global (health) justice debate. First, I will describe the main theories in global justice, which are mostly distributive. In section 1.2.2 I will analyse the relational egalitarian view, which is, in my opinion, an underexposed but interesting addition to the global health justice debate.

1.2.1 Global (health) justice theories

The debate on global justice has been going on for several years and is mainly focused on distributive questions, namely how and to whom we should distribute what resources. Critique on the distributive paradigm will be discussed in section 1.2.2, but first I will deliver an overview of the major (distributive) theories in global justice, which can be used as a background for discussion on global health justice as well. The major goal of this section is to set out whether, and if so, what duties we have in global health, mostly to position myself in the debate and investigate what my account should look like to appeal to those I want to appeal to.

An overview of global justice theories can be structured in various ways. First, these theories are distinct in whether, and if so, what type of duties we have towards our compatriots and our non-compatriots. Second, the theories differentiate between different types of duty-bearers, either the state, individuals or both. Authors that have made a clear overview of these theories and paid attention to these specific aspects are Ruger (2009), Beitz (1999) and Wolff (2011; 2012), of which the latter is particularly focused on global health. Therefore, I will mainly use his synopses, supplemented by the overviews of the other two authors. To be clear, I will simply give an overview, rather than pore over the reasons *why* theorists have argued for their positions.

First, authors with a nationalist perspective, also called statists or social liberals, argue that any health duties from justice only apply in the domestic state: the moral boundaries to the right to health are those of the state's territory (Wolff, 2011; 2012). The agents of justice, for social liberals, are states and not individuals or international actors (Beitz, 1999). The most famous social liberal, Rawls, has set out the thoughts behind this position: claiming that states would, under a 'veil of ignorance', choose to obey treaties and limits on war, but that distributive principles only apply within the state itself (Ruger, 2009). But, besides these negative duties of non-interference, he claims that states must also assist other, less regulated states in satisfying their own citizens' basic needs and human rights, as a minimum standard. A liberal view thus seems to entail some minimum positive duties of assistance – or of charity or humanity – but the primary recipients are other states and not individual non-compatriots (Wolff, 2011; Beitz, 1999). It is a bare minimum, though, as Rawls only includes in his set of human rights those to life, liberty and security but not those of freedom of thought, democratic government and most importantly for this thesis, to an adequate standard of living. Rawls' ideal would be that individual societies should be assisted to become a decent state, so that they would be able to provide these human rights for their own citizens, and no concern of justice would remain (Beitz, 1999).

Second, there are libertarian authors, or 'laissez-faire liberals' as Beitz (1999) calls them, who claim that we only have *negative duties of non-interference* with the liberty of non-compatriots, but that there are no positive health duties: not nationally let alone globally (Wolff, 2011; 2012). This is based on the idea that a distribution is just when the previous distribution was just as well as the process by which the distribution came about – by just meaning everyone's rights were respected (Beitz, 1999). A distinction can be made, though, between two types of libertarians, about what to do with the effects of previously unjust distributions. The first, argue that there is no need to repair them, as many generations of economic growth have rectified them already. The only reason to redistribute for previously unjust distributions would be for if it were in *the interest* of the state itself (Wolff, 2011). This perspective is sometimes joined by realists and normative scepticists, who claim there are no global ethical standards, so it does not make sense to think about global (health) injustices and duties (Ruger, 2009).

The second type of argument, which belongs to those that Beitz (1999) calls the 'laissez-faire redistributivists', is that it might sometimes be necessary to rectify the effects of previously unjust distributions – such as those due to colonialization and unfair trade policies – for example

by redistributing control over resources or by compensation. These are the so-called duties from *corrective justice* to our non-compatriots, which thus have to be distinguished from duties of charity, like those argued for by the nationalists. One of the first accounts of corrective injustice was that of Aristotle (SEP, 2017) and specifically, in global health, the explanation of these duties is found in that former colonialization has created the global health problems that we face now and that we thus have duties from corrective justice to solve these issues (Wolff, 2012). Although some might argue that the current agents have not 'committed' these wrongs and are thus not culpable, others have argued that precisely because current agents enjoy the benefits created by the current world order and others are harmed by it, corrective justice still needs to take place (SEP, 2017). But apart from the human right to an equal share of the world's resources, the 'laissez-faire redistributivists', just as social liberals, restrict the number of human rights, as they do not endorse a human right to subsistence or a minimum level of welfare (Beitz, 1999).

The final group of theorists does also acknowledge there are positive duties from *justice* towards non-compatriots, but not for corrective reasons. The main group of theorists that acknowledges duties from justice for other than corrective reasons are cosmopolitans (Beitz, 1999; Wolff, 2011). They claim that there are universal duties to remedy global health injustices: these duties from justice oblige the agents to help relieve someone else's unjust suffering – whether one is a compatriot or living on the other side of the globe.

Cosmopolitans can be distinguished in institutional and moral cosmopolitans. The first group is concerned with how institutions should be installed. The second group is concerned with the basis on which institutions should be justified, for example, because everyone should have equal human rights. Most cosmopolitans do indeed include a minimum right to security and subsistence in their subset of human rights (Beitz, 1999). There is disagreement, though, which actors are the duty-bearers of these human rights, either all individuals and groups (interactional conception) or only institutions and shared practices (institutional conception). For example, Pogge is an institutionalist, claiming institutions share a global responsibility and are the responsible agents to whom individuals can make claims about their human rights (Beitz, 1999). This is mostly because institutions probably have caused and are also able to remedy deprivation, Pogge claims (Beitz, 1999). The difference with nationalists is that a cosmopolitan focus is predominantly on global institutions rather than on domestic societies. Interactional cosmopolitans do admit it might be practical to devolve responsibilities to institutions, but they do not make the causal connection

between global human right deprivation and institutions, as they still think everyone is equally responsible for providing global human rights (Wolff, 2011; Beitz, 1999).

Having described several foundations of the global health duty, I am, for many reasons, inclined to hold onto the view that we have global health duties *from justice* (and not from charity). This is because duties from justice, whether corrective or not, make the agent that fails to act on them blameworthy, as duties of justice oblige the duty-bearer to act and injustice can be created by omission of these duties (Stanford Encyclopedia of Philosophy (SEP), 2017). This ensures, as Wolff describes, a more permanent and demanding appeal and asks for a continuous effort to combat global health injustices (2011). I will, therefore, in chapter two, provide an ecumenical account based on duties from justice that appeals to both cosmopolitans and social liberals. Therefore, I will show in chapter two how hermeneutical injustice can also be – partly – considered a corrective injustice. This latter view will get most explicit attention, as cosmopolitans would not need more conviction to agree with my account. But first, I will leave the aforementioned theories of justice and look at how analysing global health from a different paradigm could attribute to the global health debate.

1.2.2 Relational egalitarianism in global health

The previously discussed theories mostly concern distributive matters: what, how, who and to whom resources are and have to be distributed to ensure a just (global) distribution (Voigt & Wester, 2015). Distributive theorists argue that global health problems are to be conceived of as problems of distribution: resources such as money, or medical equipment, are distributed unequally and therefore creating injustice to the countries which lack those resources (Labonté & Schrecker, 2011). There has been a vibrant debate between distributive egalitarians and *relational* egalitarians, about what kinds of inequalities matter and whether the distributive paradigm can capture the concerns of relational egalitarians (Voigt & Wester, 2015). This section is not meant to dive deeply into the details of this debate but instead is an explanation of the relational paradigm and its relevant elements for the rest of my thesis, as a relational analysis of hermeneutical injustice – the concept I will discuss in the next chapter – can attribute to the global health debate. To be clear, I am not rejecting the distributive paradigm. Rather, I want to show that an analysis from the relational paradigm can show why certain situations in which hermeneutical resources are *distributed* fairly there is still a hermeneutical injustice taking place.

Relational egalitarians, such as Anderson (2012) and Scheffler (2005) claim that the focus on distributive elements of injustice miss out on important relational aspects. Rather than looking at equal distribution, we should be concerned with equal relationships – the way we aim to relate to one another as equals. Relational egalitarians argue that it is primarily factors such as status, rank and power that should be equal among individuals, and equal distribution of resources is of secondary relevance – or at least resources should be distributed in such a way that it serves the equality of relational factors. This is because sometimes the society that results from seemingly just distributions divides people and makes them unable to interact with each other respectfully, due to oppression and status hierarchies that came about by these transactions (Voigt & Wester, 2015). Distributive egalitarian authors differ from relational egalitarians in that they reject social inequality *only* for the distributive inequalities it produces – while relational egalitarians reject these inequalities whenever they undermine relational equality and not because these inequalities *themselves* are unfair. According to Voigt and Wester, relational egalitarians would not consider material inequality as unjust *in itself*, "but rather the unjust processes by which it has been brought about" (2015, p. 24).

How are the concerns of relational egalitarians relevant to the debate on global health injustice? It seems as relational egalitarians naturally focus on what has been discovered are important determinants of health, namely social class and income. This is an important difference with distributive theorists, who, according to Voigt and Wester (2015) have been struggling with how we should consider distributing 'health', as it is a 'natural' good rather than a material resource that can be distributed. Therefore, the main focus of distributive theorists has been the distribution of health care, as access to health care is considered to be a basic need to participate in society as equals. An addition of relational egalitarians to the debate could thus be that they can have a say about the social determinants that play a big role in determining health, but which seem difficult to be captured by purely distributive justice theories (Voigt & Wester, 2015).

Moreover, relational egalitarians tend to look at the *expressive* dimension of certain health policies rather than merely at the *outcomes* they produce. Weinstock, a relational egalitarian, has argued that the expressive dimension of health care should get more explicit attention, "because it betokens the extent to which people are treated as deserving of equal care and respect" (2011, p. 429). So, a global health policy might be just when looked at the outcomes, for example because medical resources are distributed in a just way, but the policy could still be unjust for *relational*

considerations. A health policy that *expresses* racial preferences, for example, is unjust for expressive reasons, while it might be considered just when merely looked at the outcomes of the policy.

Finally, an important reason why relational egalitarians can contribute to the global health debate is that they argue for a group-based analysis. A major contributor to this argument is Young (2001; 2009) who states that when making claims about social justice, solely assessing the situation of individuals disables us to analyse the *causes and consequences* of the inequality. While it is explicitly these factors of the inequality, rather than the pattern of inequality itself, that makes the inequality unjust. These types of injustices are called structural inequalities, Young argues (2009), and a group-based analysis is meant to show these inequalities between groups that are not visible when making analyses of individual injustices. This is for example described by Frye (1983), who provides the example of a birdcage which imprisons the bird. If we would look only at one wire at a time, we cannot explain why the bird is not free to fly. But if we look at the whole birdcage, all the wires together, the reason for the lack of freedom becomes clear.

The relational aspect of structural inequality is present in Young's definition of structural inequalities: inequalities that are "*relationally* [emphasis added] constituted through interactions that make categorical distinctions among people in a hierarchy of status or privilege" (2009, p. 363). So, again, these inequalities are group-based injustices because they constrain individuals from specific groups to have equal opportunity in society, marginalizing those groups. Young describes women, disabled people and minorities of a certain race as particular victims to structural inequality. This can be seen in women's oppression: due to certain gender roles and expectations that structures such as schools, media and employers uphold, women still tend to be the primary caretakers, which disallows them to take on a full-time job. Even if they would take a job, they would probably be earning less than men. These structural gender roles and expectations thus form a birdcage around women, making them dependent on their husband's earning. This, while individuals from other groups, such as white men, might experience privileges by the same social structures.

Young (2001; 2009) is also critical of the distributive paradigm. Classical (luck) egalitarians, she claims, such as Dworkin and Temkin, focus too much on individuals and aim for 'difference-blindness': arguing that we should be blind to differences of social membership. By trying to treat all citizens the same, though, certain individuals are still disadvantaged as they

belong to marginalized groups which are not giving due attention, according to Young. For example, a person in a wheelchair who cannot access a courtroom is disadvantaged from the fact that the state is trying to treat all citizens the same way. Moreover, she claims that judgments about distribution are only "a piece of a puzzle" (2001, p. 16) and that authors arguing from a distributive paradigm interpret other circumstances than distribution merely as 'bad luck' – while most of these circumstances are socially caused. Falling back on claiming these circumstances are 'bad luck' puts too much emphasis on the responsibility of the individual rather than critically analysing institutions that bear collective responsibility for certain groups being in structural inequality (Young, 2001).

Interestingly, these are all valid reasons why relational egalitarianism could contribute to the global health debate, but the focus of these theories has mostly been on *local* relational processes, that is to say between groups living in a certain country. This has also been mentioned by Armstrong (2009), who claims that the scope of relational egalitarians is usually constricted to states or to those who share citizenship. That is mainly because of the doubt if inequalities between unconnected groups are truly objectionable. To me, this seems like a false statement: somehow every citizen is related to one another, whether through national, international or global institutions (or even by sharing the same globe: of which climate change is a clear example) – so there should be no question whether relational inequalities on a global scale are morally objectionable. Especially in global health, these relationships are created by the design and implementation of health policies, since they are usually created by a group of people in one country for a different group in another country.

Moreover, it has been argued that specifically state structures have both a coercive and pervasive nature and that therefore the scope of relational egalitarianism should be constricted to states only. Neither am I too sure about this claim, as global health institutes that design and implement policies in different countries might just be as coercive and pervasive in individual's lives as do state institutions, especially when there is a great deal of dependency on these policies (which is considerably true in the case of global health). So, I am not convinced that the scope of relational egalitarianism should be constricted to states.

A global relational egalitarianism has been argued by few authors, such as Hausman (2012), who claims that relational egalitarian duties following from health injustices might more stringent within a country, but that all global citizens should be taken into consideration in diminishing health

inequalities and avoiding domination by specific nations. But, to the best of my knowledge, his and other positions have not been developed as much, so my thesis will fill in a gap by providing a more complete analysis of global health from the relational paradigm.

The next chapter will be devoted to the concept of hermeneutical injustice and its relation to structural inequality, and, most importantly, how it is present in global health. This will thus, as mentioned before, mainly entail an analysis from the relational paradigm, but as I have stated that my account also has to appeal to social liberals arguing for duties from corrective injustice, I will also pay attention to the – partly – distributive character of hermeneutical injustice.

2. Hermeneutical injustice

In this part of the thesis, I will explain the concept of hermeneutical injustice and the link between hermeneutical injustice and structural inequality. How these two concepts are important for the discussion on global health, and why it is important to analyse these concepts I will discuss in the sequel. To clarify the specific relevance to global health, I will give two examples in which hermeneutical injustice in global health is present.

2.1 The concept of hermeneutical injustice

Hermeneutical injustice is a form of epistemic injustice in which there is "a wrong done to someone in their capacity as a knower" (Fricker, 2007, p. 1). Fricker (2003; 2007; 2013; 2015), who distinguishes hermeneutical injustice from testimonial injustice, shows that both forms of epistemic injustice lead to a situation in which the speaker is unjustly regarded as incapable or incompetent due to structural prejudices of the group to which the speaker belongs and can therefore not make sense of his or her social experiences. Specifically, hermeneutical injustice takes place when there is either a gap in hermeneutical resources between the speaker and the hearer or a total absence of these resources, causing an unfair disadvantage to the speaker.

Systemic hermeneutical injustice should be distinguished from two other situations. The first is one where there is a total absence of hermeneutical resources which hermeneutically disadvantages certain individuals, but no unequal hermeneutical participation and no hermeneutical injustice. This takes place when, for example, a patient has a medical condition that has not been understood by the medical world (yet). Although he or she is hermeneutically disadvantaged, as he or she cannot make sense of his or her social experiences that are influenced by his or her undiscovered medical condition, there is no situation of unequal hermeneutical participation and no hermeneutical injustice but rather he or she is a victim of incidental *epistemic bad luck* (Fricker, 2007).

The second situation is one where there is a gap of hermeneutical resources that does cause unequal hermeneutical participation and therefore a hermeneutical disadvantage, but there is no hermeneutical injustice. An example of this is when a state blocks certain websites for its citizens, causing what is called *epistemic isolation* (Kidd & Carel, 2017). All inhabitants of the country are then being disadvantaged to the same extent because they are not given access to the hermeneutical

resources they need. No specific individuals or groups are harmed, which does not make it a situation of hermeneutical *injustice*.

So, it seems that there is something different to these situations than to situations of actual hermeneutical injustice. What makes the aforementioned situations turn into situations of hermeneutical injustice? Two criteria have to be distinguished here. Fricker does implicitly describe them (2007), but, in my view, these need to get more explicit attention to distinguish situations of hermeneutical injustice of the other situations sketched above.

The first criterion is that there must be a *structural prejudice* against the group that is hermeneutically disadvantaged (the speakers), which causes them to be marginalized by the hearers. In the aforementioned examples, there is no structural prejudice against the so-called 'speakers' and thus no hermeneutical *injustice*, but merely a hermeneutical disadvantage due to individual epistemic bad luck or to systemic epistemic isolation (Fricker, 2007; Anderson, 2012).

The second criterion is that there must be a background situation of *structural inequality* in which hermeneutical injustice takes place, which harms different individuals or different groups unequally compared to others and thus *hermeneutical marginalisation* takes place. So, due to structural inequality, a situation of hermeneutical injustice is only unfair to the speaker, *but not to the hearer* (Fricker, 2007). Because the link between structural inequality, a concept already explained in chapter one, and hermeneutical injustice has, to the best of my knowledge, been underdeveloped in the literature, I will explain the connection between the two more elaborately in section 2.2. First, I will elaborate on situations of actual hermeneutical injustice, to make the concept clearer.

The first example of hermeneutical injustice is given by Kidd and Carel (2017), in which they describe how physicians tend to have prejudices towards their patients for some might think ill people are not epistemically reliable. In not taking their patients seriously, the patient is being wronged, for he or she cannot make sense of his or her social experiences towards the physician, which could end up in severe disadvantages for the patient – for example by misdiagnosing their illness or unnecessary referral (Kidd & Carel, 2017). This, while he or she might be perfectly able to explain his or her experiences of the illness towards another patient. The gap in hermeneutical resources eventually disadvantages the patient while the physician does not experience a disadvantage (or maybe disadvantage from a different kind, namely the 'shame' of misdiagnosing or indirectly, the healthcare costs caused by unnecessary referral). The structural inequality here,

according to Kidd and Carel (2017), is caused by structural features of modern healthcare practice, which deem the experiences of ill persons inappropriate for public debate and are excluded from contributing to clinical decision-making. It is thus clear that, next to structural prejudice, a background situation of inequality between the speaker and the hearer decides whether unequal hermeneutical participation and disadvantage is genuinely a hermeneutical *injustice.*

To illustrate this further, I will discuss another example, in which the structural inequality is even more visible. Fricker (2007, p. 3-5) describes a time in history in which there was no word yet for men's sexual harassment of women. So, women who experienced this in their workplace, could not make sense of this social situation, because there were simply no resources to describe the phenomenon of sexual harassment. Fricker explains the case of Carmita Wood, who experienced sexual harassment by a male co-worker at her workplace. At first, she tries to avoid him, but eventually, she develops physical symptoms of stress and decides, after being refused to be placed at a different department, to quit her job. When applying for unemployment insurance, she was unable to explain what had happened to her in her previous job and why she quit. Accordingly, she was denied unemployment insurance. This example shows that structural prejudices against women as well as a background of structural inequality, in which women were in an unequal power relationship to men, turn the situation into a hermeneutical injustice for the harassed, *the speaker*. The harasser, although he also misses hermeneutical resources to describe the situation, does not experience a hermeneutical disadvantage. While on the other hand, Carmita's hermeneutical disadvantage is particularly *unjust* because of the sexist prejudices against women and a structural inequality between men and women, which made her powerless to stand up against the situation. For these conditions were not present in the earlier mentioned examples of epistemic bad luck and epistemic isolation, those were not situations of hermeneutical *injustice* as is the situation of Carmita.

Finally, important to note, as we will see in section 2.3, is that hermeneutical injustice is not something the hearer, or anyone else, is *responsible* and thus *culpable* for (Fricker, 2013). It is a process that takes place unknowingly, and especially because such a big component is structural, there is no direct person or institution that can be designated for the injustice taking place. The fact that no one willingly 'commits' hermeneutical injustice also has consequences for the virtue of hermeneutical justice, which I will describe in chapter three.

This section has made clear that to create a hermeneutical *injustice*, unequal hermeneutical participation must take place against a background of (1) structural prejudice against the group to which the speaker belongs and (2) structural inequality. As mentioned before, the first criterion is well explored by Fricker (2003; 2007; 2013; 2015) and Anderson (2012), but the second, to the best of my knowledge, misses a deeper analysis. Therefore, I will more elaborately explain the link between Young's concept of structural inequality (2009) to hermeneutical injustice in the next section. Afterwards, in section (2.3), I will show how hermeneutical injustice takes place in global health and provide specific examples.

2.2 Hermeneutical injustice and structural inequality

I have already given several examples in which a situation of unequal hermeneutical participation turns into a hermeneutical injustice, due to the presence of the two criteria of structural prejudice and structural inequality. The link between structural prejudice and hermeneutical injustice has been explored well by Fricker (2007), but the relationship between structural *inequality*, the concept described by Young (2009) and explained in section 1.2.2, and hermeneutical injustice has not been given that much attention in the literature. In my opinion, though, they are strongly related. This section will be devoted to the interconnectedness of the two concepts.

To recap, Young explained structural inequality as the situation in which "persons categorized in the subordinate positions generally face greater obstacles in the pursuit of their ambitions and interests, or have a narrower range of opportunities offered to them for developing capacities and exercising autonomy of their action" (2009, p. 363). Persons in these subordinate positions are, according to Young (2009) for example women, disabled people and minorities of a certain race. These people will thus experience hermeneutical injustice whenever there is a situation of unequal hermeneutical participation and structural prejudice, while people that are not in these subordinate positions and thus not a victim of structural inequality might only suffer from unequal hermeneutical participation. Especially the background situation of structural inequality, as we saw in the example of Carmita Wood, makes the situation *unjust* rather than merely a disadvantage. So, the first connection between structural inequality and hermeneutical injustice is a causal link.

There are also other ways in which the two concepts are connected. First, the factors contributing to structural inequality all involve *communication* and thus in one way or another the use of hermeneutical resources. Most directly this is seen in Young's definition of culture, which

is one of the components of structural inequality, for example, because the habitus of dominant cultures is normalized, while that of other cultures is marginalized (2009). She defines culture as "the symbols, images, meanings, habitual comportments, stories and so on, *through which people express their experience and communicate with one another"* [emphasis added] (2009, p. 373-374). Whenever a culture of a minority is different and makes use of the non-dominant hermeneutical resources, this may cause the group to which this culture belongs able to express their experiences and communicate *within the group* but they might not be understood and even hermeneutically marginalized by other groups with the dominant hermeneutical resources. This can, of course, strengthen or even produce structural inequalities between these groups. Therefore, it seems as if the link between hermeneutical injustice and structural inequality works two ways: not only does unequal hermeneutical participation become hermeneutical injustice *because of structural inequality* as is explained in the example of Carmita Wood, hermeneutical injustice also seems to contribute to structural inequality: different cultures have different hermeneutical resources, which could cause a gap between groups and thus increase the structural inequality if the group with the non-dominant hermeneutical resources is being marginalized. Not only is structural inequality thus causally linked to hermeneutical injustice since it must be present in the background, a hermeneutical injustice suffered by different, marginalized cultures might also contribute to structural inequality the other way around.

Second, structural prejudice, the other criterion that turns unequal hermeneutical participation into hermeneutical injustice, is also influenced by structural inequality. So, structural inequality contributes to hermeneutical injustice in two ways: one by its direct influence on hermeneutical injustice, and one indirectly, through its influence on structural prejudice. In my view, structural inequality contributes to structural prejudice because the structural gender roles and expectations that Young described, can if upheld long enough, turn into prejudices. I am not claiming here exactly how this works out since this would be a sociological or anthropological question, but in my opinion, it is imaginable that a certain stereotype of women as caretakers can turn into prejudices about women being 'softer' or less 'powerful' than men. As important structures such as schools and media enforce these gender roles and expectations, these can be taken over and become prejudices by the majority of society. This clearly plays out in the example of Carmita Wood, in which the structural inequality that was present between men and women, made them powerless to stand up against the domination by men, re-enforcing the structural

prejudice of women being 'soft' and 'powerless' (Beeby, 2011). And again, were it not for these structural prejudices against women, due to the structural inequalities between men and women, the unequal hermeneutical participation of women would not have to actual hermeneutical injustice.

Finally, both structural inequality and hermeneutical injustice are *relational* concepts. I have described the relational paradigm in section 1.2.2, it is clear that structural inequality and hermeneutical injustice are both about the way we relate to each other as human beings, not merely the way we distribute (hermeneutical) resources. Hermeneutical injustice, for example, can be present even in situations in which the hermeneutical resources are equally distributed: for example, in the situation of Carmita Wood. Although both the speaker (Carmita Wood) and the hearer (the harasser) lacked the hermeneutical resource for 'sexual harassment', only Carmita experienced hermeneutical *injustice*, for it was due to structural inequality and structural prejudices against women that the unequal hermeneutical participation turned into hermeneutical injustice. So, an analysis from the distributive paradigm could have missed this severe injustice, as it does not take into account (sufficiently) the relational aspects that play a major role in structural inequality and hermeneutical injustice. This is also mentioned by Fricker, who claims that epistemic justice is about the way people relate to each other, rather than about distribution of resources – and that relational equality supports distributive equality since it "entails the equal weighing of people's interests" (2015, p. 5).

So, structural inequality and hermeneutical injustice are evidently related: they are causally connected in the way (1) structural inequality attributes to hermeneutical injustice and (2) hermeneutical injustice re-enforces structural inequality and (3) in the way structural inequality increases structural prejudices and thus indirectly contributes to hermeneutical injustice. The last connection is not causal but about the relational aspects they share: both concepts focus on how we relate to each other rather than on distributive matters.

In the next section, I will elaborate on hermeneutical injustice in global health and show how its two important components – structural inequality and structural prejudice – are present in global health. I will give two, more specific examples to clarify this. Moreover, I will, besides this *relational* analysis of hermeneutical injustice in global health also pay attention how the concept can partly be considered a distributive matter, specifically a *corrective injustice*, to appeal to the duties from justice argument by social liberals.

2.3 Hermeneutical injustice in global health

I have now discussed the concept of hermeneutical injustice and the link to structural inequality between groups *within states*, as this seems to be the focus of most relational egalitarians (see section 1.2.2). Accounts of Fricker (2003; 2007; 2013; 2015) and Anderson (2012) on hermeneutical injustice, as well as Young's description of structural inequality (2001; 2009) also seem to describe local situations of hermeneutical injustice and structural inequality. Fricker does mention the possibility of hermeneutical injustice on a global scale (2013), but for what I have noticed, her account lacks specific examples. Therefore, my thesis will fill in the gap of analysing hermeneutical injustice on a global scale, especially within global health. In this section I will provide this analysis, using the framework I have explained in section 2.1, that a hermeneutical injustice must consist of unequal hermeneutical participation, structural inequality and structural prejudice against the speaker.

It does not need much explanation that *if* there would be hermeneutical injustice in global health, the Global North should be interpreted as the 'hearer' and the Global South as the 'speaker'. So, the analysis must show that countries and/or individuals living in the Global South are experiencing hermeneutical injustice in global health due to unequal hermeneutical participation against a background of structural inequality and structural prejudice of the Global North against the Global South. The first criterion, the presence of unequal hermeneutical participation of the Global South in global health, will be specifically explored in the examples given in section 2.3.1 and 2.3.2. What I will discuss here, primarily, are the other two criteria, that of structural prejudice and structural inequality between the Global North and the Global South.

Considering the first, studies have found that many prejudices about the Global South are present, mainly caused by news media that display countries and its leaders close to the colonial representation (Avraham & Ketter, 2016). The Global South is being portrayed as, among other things, dangerous, primitive, full of crime and epidemics and populated by uneducated inhabitants (Avraham & Ketter, 2016). In my view, especially this latter stereotype can easily turn into prejudices about people living in the Global South and thus be a potential major contributor to hermeneutical injustice. The media also supplies the tendency of people in the Global North to blame inhabitants or governments of the Global South of being responsible for negative events: as it being part of their 'nature'. Most crucial is the 'us' versus 'them' trend that is being caused by prejudices: people in the Global North feel different to people in the Global South – a fruitful basis

of hermeneutical injustice, as feeling different to another group can easily lead to the marginalization of that other group (Avraham & Ketter, 2016). Other research has also shown how media plays a major role in shaping adolescents' image of the Global South, and that negative stereotyping in the public discourse is a major contributor to these prejudices as well (Strabac & Listhaug, 2008). Besides the influence that a big institution like the media has on structural prejudices, Bason (2011) has also shown how education contributes to upholding these prejudices. Textbooks used in the United States include wrong facts, such as that Africa consists of tribes, contributing to the idea that the continent is primitive, and that Africans are uneducated. Both media and schools are institutions that massively influence our way of thinking, and thus can easily contribute to structural prejudice as a basis of hermeneutical injustice.

The second criterion, which is the background situation of structural inequality, does not need much explanation for its presence in global health. Major differences in life expectancy, mortality rate, education inequality and wealth are still present (Moellendorf, 2009). These inequalities cause unjust power structures since the Global North is dominating the Global South in negotiations and institutions and thereby re-enforcing the structural inequality between the two (Moellendorf, 2009). Without diving into the discussion about showing how this structural inequality came about, it is fair to state that for example, globalization has negatively influenced it. Held and Kaya state it "impedes development, exacerbates inequality and makes the poor worse off in many parts of the world" (2007, p. 2). Structural inequality has not merely to do with income inequality – a distributive matter – but also more structural determinant such as a health care system of good quality and public health measures that have a much greater impact than income on health (Pradhan, Sahn & Younger, 2003).

Moreover, the HIV/AIDS pandemic shows the structural inequality that is present in global health. Most individuals that are infected with HIV live in Africa, while the infection originated in the United States of America. Also, therapy has become readily available to HIV-infected patients in the United States of America while due to high costs and patents on multidrug therapy, it is, even in African countries with advanced medical facilities, difficult to make low costs alternatives affordable for African patients (Hunter, 2003). This, while parts of research into this multidrug therapy have taken place on uninformed and unwilling subjects in Africa (Meier, 2002). Although part of this problem is, of course, distributional, these inequalities also show major relational and structural components, as institutions that uphold these patents on therapy and perform science on

the unknowing African population show unequal *treatment* of Africans than of Americans, which is both a relational and a structural issue. Furthermore, the individuals still infected with HIV in the Global North are mostly of racial and ethnic minority populations, showing how these groups suffer from structural inequality in health. Again, globalization has been mentioned as the major contributor to this structural inequality, together with the way, for example, the World Bank is giving loans instead of donations to combat HIV/AIDS in the Global South (Parker, 2002).

These are just some short descriptions of how structural prejudices and structural inequality are present in global health: the conditions for hermeneutical injustice. Before going to the next section to show specific examples of hermeneutical injustice in global health, it is important to mention a trend in the literature on hermeneutical injustice on a global scale, to which neither Fricker nor I agree.

I have already noted in section 2.1 that Fricker (2013) claims hermeneutical injustice is not something anyone is to blame for as it takes place unknowingly. This is an important statement since there is a specific trend going on in the literature on hermeneutical injustice on a global scale in which it is claimed *to be* happening knowingly. I want to make this clear since it is important for my thesis as well and argue why I agree with Fricker that this is a misconceptualization of her account.

Authors like Dotson (2012), Medina (2013) and Pohlhaus (2012) have interpreted parts of Fricker's account as follows. They claim that the Global North is *intentionally* creating hermeneutical injustice and that it is a part of white ignorance. Dotson (2012), for example, states that the hermeneutical injustice that the Global South is experiencing originated in colonial times. In his view, the Global North destroyed the Global South's hermeneutical resources through colonialization, while indigenous hermeneutics were widely present across Africa and South America. By colonialism, the Global North's hermeneutical resources became the dominant ones, while the indigenous' hermeneutical resources were marginalized. Because the current global structural inequality between the Global North and the Global South has become more present after colonialism and neo-colonialism, Dotson (2012) relates colonialism to the current unequal global situation. Combining the possibility of hermeneutical injustice as a legitimating power and the global structural inequality between the Global North and the Global South, Dotson (2012) argues that ignoring this hermeneutical injustice serves the Global North since it legitimates not alleviating the global injustices that are taking place and thus holding on to the status quo. Dotson (2012)

claims this is a 'contributory injustice' caused by 'situated ignorance'. Others have also claimed that this 'white ignorance' that leave black citizens ignored should be categorized as a hermeneutical injustice (Medina, 2013; Pohlhaus, 2012).

Fricker disagrees with this and states that this is a misinterpretation of her account (2013). She does mention that hermeneutical injustice could become a source of legitimating power (2007), but that the rest of the argument by Dotson and other rests on a misconceptualization (2013). To show this, the case of Carmita Wood is a good example. We have seen that because Carmita has no way of making sense of her social experiences, the man can continue the sexual harassment. Eventually, when this hermeneutical injustice is not uncovered, this could even become a source of legitimating power, Fricker states. She mentions that the powerful can "indeed have a positive interest in sustaining the extant misinterpretation" (2007, p. 152). But although this might be true, no one is *intentionally causing* hermeneutical injustice. In her view, this injustice is structurally unjust, but not epistemically culpable (2013). Situated or white ignorance, she argues, surely shows wrongful epistemic dysfunction and is also blameworthy in situations in which the hearer is racist since situations of motivated irrationality are always culpable. But this is not a case of hermeneutical injustice since there are no hermeneutical lacuna or missing concepts but rather "a lack of epistemic self-discipline to apply the extant resources in an epistemically responsible way" (Fricker, 2013, p. 51): injustice on a doxastic level rather than on a conceptual level. The only 'case' Fricker seems fit to be headed in the category of hermeneutical injustice is that in which ignorance is the consequence of structural hermeneutical marginalization which might be due to intentional privileged interestedness as much as to "unintended consequences of social flux" (Fricker, 2013, p. 51). But, in this case, white people are the ones who experience a hermeneutical gap since they cannot properly understand the social situation, *but they are not the ones disadvantaged by it*. So, for white ignorance to be a form of hermeneutical injustice, it is not black people who need to be disadvantaged, but the white – and that is not the case for white ignorance. For it to be a hermeneutical injustice, it must be in the interests of *the ones marginalized and thus disadvantaged* to develop or uncover certain concepts to decrease the hermeneutical gap, which, in case of white ignorance, is exactly the other way around. This does not mean that there is not an injustice going on: situated ignorance is an injustice, but it must be viewed as a different form of epistemic injustice next to testimonial and hermeneutical.

I am inclined to follow Fricker her, as she provides a strong reaction to Dotson and the other authors. It has been clear from the examples that Fricker gives, and that I have mentioned in section 2.1, that the hearer does not 'commit' the hermeneutical injustice knowingly, specifically because it is precisely the *structural* factors that make the situation unjust. And although in an individual, local situation of unequal hermeneutical participation, the hearer might be culpable for the hermeneutical injustice since he or she is racist, this account is difficult to hold on a global scale, as the hearer and speaker are more unspecific groups or individuals.

This is also an interesting consideration for the final part of this section, in which I will pay attention to the question whether hermeneutical injustice can be partly a corrective injustice. As I mentioned in chapter one, I want my account to appeal to cosmopolitans and social liberals. The first group must already appeal to the fact that hermeneutical injustice is global health is an injustice *in itself* since it leads to some individuals being less healthy than others – while they consider every citizen equally in their scope of justice. The second group, however, must be convinced by providing an account of corrective injustice, since only that type of injustice allows for a claim of justice by those who are harmed by this corrective injustice.

So, I must show that hermeneutical injustice can also partly be corrective, and thus be partly distributive. Although I have shown that no one is to blame for hermeneutical injustice on a global scale, Dotson's example of colonialization still has strength. It shows, namely, that indeed hermeneutical resources were taken from indigenous people that has resulted in a gap in hermeneutical resources between the Global North and the Global South. Although the hermeneutical injustice that is present between the Global North and the Global South might not be epistemically culpable, as it has taken place unknowingly and by agents that lived generations ago, it can still be seen as an injustice that has to be corrected for. Important here again is that even social liberals have argued that corrective injustice might still take place even if, currently, agents in the Global North are not 'actively' committing any wrongs to the Global South in the context of global health (SEP, 2017). Still, this results in duties from corrective justice for the Global North towards the Global South as they are still benefiting from the order that is created by previous harm. So, this shows how hermeneutical injustice can still be considered corrective, as an account of corrective justice does not need a culpable agent for it to yield duties from justice.

Concluding this section, hermeneutical injustice in global health is thus present, because unequal hermeneutical participation and structural inequality are present between the Global North

and the Global South, as well as structural prejudice of the Global North against the Global South. Moreover, Fricker has shown clearly how hermeneutical injustice is not epistemically culpable, which still allows for a consideration of hermeneutical injustice as corrective injustice – therefore appealing to the account of social liberals. Having shown, thus, that hermeneutical injustice in global health is both a relational and a corrective injustice, a normative account given in chapter three should be appealing to both cosmopolitans and social liberals. But first, I will discuss paternalism and the medicalization of global health as specific examples of hermeneutical injustice in global health.

2.3.1 Paternalism in global health

One of the most striking examples of hermeneutical injustice in global health is that of paternalism, which, to the best of my knowledge, has not been described before or developed as much as being unequal hermeneutical participation neither a hermeneutical injustice. For this example, I will first describe what paternalism in global governance looks like using Barnett's argument (2012) and then apply it in a global health context, by showing how double review in biomedical research is a form of paternalism as hermeneutical injustice in global health. I will do this by showing that there is unequal hermeneutical participation of the Global South including the two criteria that turn this into a hermeneutical *injustice,* namely that (1) there are certain (paternalistic) prejudices from the Global North towards the Global South that tend to marginalize the Global South and (2) that there is a background situation of structural inequality.

Paternalism is defined by Dworkin as "the interference with a person's liberty of action justified by reasons referring exclusively to welfare, good, happiness, needs, interests or values of the person being coerced" (1972, p. 65). Examples of paternalism are images of the consequences of smoking on cigarette packages to stop people from buying cigarettes and thus from smoking. Paternalism has mostly been criticized by liberal authors, for example, Dworkin (1972), who struggle with the fact that, although paternalism aims for the wellbeing of the targeted person, he or she is still coerced in his or her choice-making. As a response, Thaler and Sunstein, who defend a 'libertarian paternalism', state that the available options are still the same but just arranged in a different order. Still, paternalism is criticized for it being an interference in an individual's autonomous choice by someone who claims to make better judgments of what is good for that particular individual (Thaler & Sunstein, 2003).

How paternalism turns out on a global scale has been well explained by Barnett (2012). He claims that institutions in (humanitarian) global governance tend to act on the idea that the interventions they undertake are generally in the interest of the targeted populations but that these interventions are usually performed without asking for 'consent' of these populations. It is not immediately clear, he claims, that the 'gifts' that global institutions give to these communities are actually welcomed, and sometimes even given against the will of the intended beneficiaries. So, in my interpretation of Barnett: it is clear that what is missing in paternalistic governance is the consultation of the beneficiaries and their participation in the debate on what they genuinely need.

Could this mean paternalism is a case of hermeneutical injustice in global health? It, therefore, needs to meet the aforementioned criteria. First, it has to be sure that paternalism causes unequal hermeneutical participation of the Global South. As is clear from the definition of paternalism is that it interferes with an individual's autonomous choice by someone who claims to be a better judge of what is good for that particular individual. The individual is not *participating* in this judgment: he or she is not asked whether he or she agrees with the aim of the paternalistic act. Therefore, you might say that also on a global scale, paternalism does indeed lead to a situation of *unequal hermeneutical participation*. This has also been emphasized by Barnett (2012). He shows that there is a difference between 'shallow' participation, meaning that local populations are included in the implementation of policies, and 'strong' participation, meaning that communities themselves decide what suffering is and are thus participating in the *formulation* of policies. This latter participation seems to lack in many global policies, where the focus is mostly on the donors instead of the recipients. For me, this lack of 'strong' participation is exactly what unequal hermeneutical participation of the Global South is: paternalistic policies by the Global North, in which they decide what is needed in the Global South, show a *hermeneutical gap* which disadvantages the Global South. It shows how the Global North, the hearer, unjustly regards the Global South as incapable or incompetent by not including the Global South in formulating these policies. Therefore, a situation of unequal hermeneutical participation exists.

Moreover, for this unequal hermeneutical participation to become an *injustice*, it has to meet the two criteria mentioned before. First, there must be a scenario of structural inequality between the Global North and the Global South. This has already been shown earlier. Second, the Global North must have certain prejudices towards the Global South that tend to marginalize the latter. I have already sketched some general prejudices of the Global South by the Global North.

These prejudices become even clearer in paternalism, especially when considering it from a relational paradigm. Relational egalitarians, namely, have not been criticizing paternalism for its coercive character – as is the biggest concern of liberal authors (Thaler & Sunstein, 2003) – but for *expressive* considerations (Voigt & Wester, 2015). Paternalistic public health policies, namely, tend to imply that the individuals or groups for which the policies are intended are deficient or short of rationality or intelligence that needs to be corrected through paternalism – while those implementing the policy do have these capacities (Voigt & Wester, 2015). Thus, by the way, paternalistic interventions *express* a lack of respect or recognition for the groups or individuals that the policies are aimed at, it shows the *prejudicial* character of paternalism. This also follows from psychological research: psychologists distinguish a 'paternalistic prejudice' which means a prejudice "towards the incompetent but nice, subordinate outgroup" which is one of the two most dominant prejudices (Fiske, 2000, p. 313). So, prejudices and paternalism go hand in hand, and although it seems like this type of prejudice in which the 'other' is seen as nice cannot do much harm: it is still shown to be one of the attitudes attributing to racism (Fiske, 2000). On a more global level, this is also present and enforced by the aforementioned stereotypes that are displayed by the media, in which a clear 'us' versus 'them' picture is created (Baker, 2015). Baker, in his research into the influence of race on foreign aid, showed that white Americans were more favourable to donate to foreign people of African than of East European descent because of an underlying racial paternalism that underestimates Africans' agency (2015). I would like to call this a 'global paternalistic prejudice', which is, in my view, a major contributor to paternalism being a global hermeneutical injustice as it is completely concerned with the way the 'speaker' is judged as being incompetent. From this, we can conclude that paternalism meets the three criteria of hermeneutical injustice: (1) there is unequal hermeneutical participation of the Global South, against a background of (2) structural inequality between the Global North and the Global South and (3) paternalistic prejudices of people living in the Global South as being incompetent.

All that is said could apply to global issues in general, so therefore I will offer an example of paternalism in global *health* more specifically, in which the seriousness of the issue is emphasized. A quite specific example is that of double ethical review for (bio)medical research taking place in the Global South. Several widely recognized guidelines, such as the CIOMS Ethical Guidelines (2016), recommend performing double ethical review of a research plan that is taking place in the Global South, meaning that both the funding and the host country independently

perform ethical review of the research project. In cases in which the host country is 'poorly regulated', it is even promoted by the European Medicines Agency that review should be done by an ethics committee that uses an ethical framework close to that of the European Union (Ravinetto et al., 2011). The reason for this is to prevent 'unethical' research that would not be accepted in the Global North and therefore should also not be performed in the Global South. So, although at first instance this seems to protect research subjects in the Global South, it has also been said to be paternalistic (Ravinetto et al., 2011). Already in considering the ethics committees of certain countries 'poorly regulated' shows a paternalistic prejudice, one of the criteria for paternalism to be a hermeneutical injustice. Moreover, it is clear that there is unequal hermeneutical participation of the Global South, especially when it is already stated beforehand that the funding country's ethical review can prevail over that of the host country once the latter is 'poorly regulated'. This has also been shown in practice: researchers in the Global South showed that almost half of the studies were not reviewed by the host country's ethical committee, while one third was funded by the United States (Hyder et al., 2003). Finally, the criterion of structural inequality is present, as described before, but more specifically in global health research, it is clear that because the Global North is funding the research in the first place, they are much more powerful in the collaboration and deciding on the agenda. This maintains the structural inequality that is already present in global health research, namely that pharmaceutical companies are focused on profitable drugs, which are mostly bought by countries in the Global North (Anderson, 2014). The severe Ebola crisis showed how few drugs were being researched since countries in the Global South did not have money for an expensive vaccine which would have led to a loss in profit for pharmaceutical companies (Anderson, 2014). By giving less attention to these serious diseases in the Global South, a structural inequality between the two parts of the world is maintained and contributing to paternalism as a hermeneutical injustice in global health.

So, the problems with double ethical review, or even single ethical review by the funding country are a specific example of paternalism as a hermeneutical injustice in global health. In chapter three, I will investigate whether Fricker's virtue ethics account (2007) can be a solution to paternalism as a hermeneutical injustice in global health, and if not, what approach would be better. But first, I will present another example in which hermeneutical injustice in global health becomes clear.

2.3.2 The medicalization of global health

The medicalization of global health can also be considered a form of hermeneutical injustice in global health. First, I will unpack the concept of medicalization as hermeneutical injustice. Second, I will discuss medicalization in global health. Finally, I will connect these two arguments and see how medicalization as a hermeneutical injustice in global health works out.

Medicalization is the process by which behaviour or somatic experiences that previously did not fall within the scope of medicine are interpreted as medical, as diseased (Wardrope, 2015). So, for example, the normal behaviour of an abundant child might get medicalized into being a hyperactive disorder. This obviously can have severe consequences, such as unnecessary treatment, but it is also a wrong in itself, as is shown by Wardrope (2015).

She namely interprets medicalization as a hermeneutical injustice. Wardrope pinpoints the problem well: "medicalization prescribes what reasons are deemed legitimate in determining how to live our lives" (2015, p. 342). Although medicalization can, of course, be seen as wrong for its outcomes, such as excessive healthcare costs, Wardrope claims it is also wrong because it is a hermeneutical injustice: it disables the ill person to understand his or her social experiences (2015). This is comparable to the case of hermeneutical injustice given in section 2.1, in which physicians' structural prejudices of patients against a background of a structural unequal health care system were present as conditions for the hermeneutical injustice – which disadvantaged the patient rather than the physician. Medicalization is an example of such a situation but, in my view, might even harm people that are not (yet) in a physician-patient relationship, since medicalization turns states that we previously considered as 'normal' to states of disease. For example, the abundant child, as described before, is made unable to make sense of its social experiences as it is made to think it has a certain disease, for which it has to take medication. It leaves no space for self-interpretation of its behaviour. Moreover, in my opinion, medicalization might be considered even more unjust than other hermeneutical injustices in patient-physician relationships in that it provides a bigger advantage to the 'hearer', who owns the dominant hermeneutical resources. In the first example, the doctor is not advantaged by the hermeneutical injustice: for example, over- or underestimating the situation of the patient can lead to an unnecessary referral which could also harm the doctor (to a lesser extent). But, in the case of medicalization, there is a certain advantage for the hearer: as Wardrope (2015) rightly points out, medicalization suits the pharmaceutical industry, for example. In that sense, medicalization causes an even bigger difference between the advantages of the

hearers and the disadvantages of the speakers, making it a bigger inequality and considerably also a bigger injustice. Wardrope devotes specific attention to medicalization in psychiatry, taking it as far as claiming that diagnosing depression or attention-deficit hyperactivity disorder (ADHD) as a "tool of oppressive socialisation" (2015, p. 344) of the 'ill' that are made unable to articulate resistance and excludes their own understanding of their behaviour. I am not too sure about this extreme argumentation, but I think the rest of her argument is very interesting. She mentions this type of medicalization as a hermeneutical injustice takes place mostly in psychiatry, pregnancy and postnatal health care, preventive medicine and health promotion (2015), which are, except for psychiatry, major fields in global health. Therefore, this is a good moment to zoom out and look at how this phenomenon is translated to a global scenario.

Wardrope's argument is not specifically meant for global health, because she focuses mainly on the role of physicians and researchers and their relation to patients. Meanwhile, Clark (2014) has set out several areas in which medicalization in global health is visible. Her different articles zoom in on medicalization of global mental health, non-communicable disease and the universal health coverage campaign. In general, she states that medicalization of global health is visible in, among other things, the huge involvement of technological and pharmaceutical industry and the discounting of social determinants in global health. The combination of these aspects is, in my opinion, interesting to analyse: could the medicalization of global health, seen in the focus on technological and pharmaceutical solutions rather than social determinants of health, be a form of hermeneutical injustice between the Global North and the Global South in global health?

To make this analysis, it can be useful to give an example. Clark (2014) mentions the report by Global Health Watch (2014), which analyses the child malnutrition program by UNICEF, an organisation mostly funded by countries in the Global North. The report criticizes UNICEF for trying to combat child malnutrition by ready-to-use foods, rather than looking at social determinants such as poverty, food pricing and trade policies that are the causes of malnutrition in the first place (2014).

Could this example indeed meet the criteria of a hermeneutical injustice? First, there has to be a situation of unequal hermeneutical participation. Most clearly, this is seen in the fact that UNICEF donated a huge amount of ready-to-use foods to India without consultation of the Indian government. India, in this case representing the Global South, obviously suffered from unequal hermeneutical participation: no efforts were taken to investigate whether these foods were needed

or wished for, while it was already proven that a mix of rice and legumes made by Indian women in the communities was an effective treatment of malnutrition and widely used in India. Although this might seem an incidental case, it is illustrative for medicalization being a form of unequal hermeneutical participation. The commercialization and therefore huge distribution of ready-to-use-foods to treat a disorder that can be dealt with by local resources other than medication seems to show that the Global South cannot fully contribute to the conversation on malnutrition and is therefore unequally hermeneutically participating. While countries in the Global South probably own perfectly fine hermeneutical resources to explain the complexity of malnutrition and its solution to other countries in the Global South, it does not come across to countries in the Global North who own the dominant hermeneutical resources. Moreover, the medicalization of malnutrition also presents ready-to-use foods as the only medicine to treat and even prevent malnutrition, while negatively framing therapeutic feeding centres or even leave out recommending proper breastfeeding, making these latter (cheaper, and better!) interventions fall outside of the conversation (Global Health Watch, 2014). And, maybe even more important, these medicalization strategies refuse to pay attention to the underlying structural causes of malnutrition, as mentioned before. So, it seems fair to say that there is a clear unequal hermeneutical participation, maybe even full hermeneutical *exclusion*, seen from the medicalization of malnutrition. But is it also a hermeneutical *injustice*?

Therefore, it has to meet the two other criteria. First, there must be certain prejudices from the Global North towards the Global South that tend to marginalize the Global South. The prejudices I described before, in section 2.3 and the example of paternalism in global health also play a role here. More specifically, Howard and Millard (1997), have described particular stereotypes of people in the Global South about the way they relate to their children: ideas that they let their children die out of ignorance or because ‘life is cheap’. A maybe less extreme example of prejudice when it comes to malnutrition is given by Bason (2011), who showed that American textbooks only show pictures of malnourished children, without paying attention to what malnutrition exactly is and what its causes are. This contributes to upholding the idea that Africa is full of starving children (Bason, 2011). The presence of these structural prejudices of people in the Global South – e.g. that they might either be too lazy or ignorant to feed their children properly – seems to turn medicalization of global health, in which ‘quick interventions’ of malnutrition are

provided, from a mere unequal hermeneutical participation of the Global South to a case of hermeneutical *injustice*.

For the medicalization of global health to be fully considered a hermeneutical injustice, one final criterion has to be met: a background situation of structural inequality needs to be present. Besides an obvious distributional inequality of food which contributes to malnutrition in the Global South, Global Health Watch (2014) showed that nutritional status is also influenced by, among other things, political instability and climate change, which both are factors of structural inequality which tend to disadvantage some groups, in this case, people in the Global South, more than others. More specifically, it has been shown that the position of women, whose breastfeeding is a major contributor to prevent malnutrition, is not sufficiently recognised (Global Health Watch, 2014). They usually have double work and care responsibility, and do not get maternity benefits such as paid leave and wage compensation. It thus seems that besides a structural inequality between the Global North and the Global South in general, women are also disproportionally affected because of their double role in the household and thus their inability to sufficiently breastfeed their children, which makes them have to fall back on the medicalized 'treatment' of malnutrition. Structural inequality is thus apparent at many levels in the medicalization of global health, making it a fruitful basis for hermeneutical injustice. This is also mentioned by Global Health Watch (2014) and by Clark (2014): such short-term interventions and other medicalization strategies risk reinforcement of medicalization and further disempowerment of people (in the Global South), making the structural inequality that contributed to this form of hermeneutical injustice even bigger.

So, concluding this section, both paternalism and medicalization of global health can be seen as examples of hermeneutical injustice in global health, as both meet the three criteria of unequal hermeneutical participation, structural prejudice and structural inequality. I have provided an analysis of double ethical review and malnutrition as more specific situations of how paternalism and medicalization in global health work out, respectively. In the next chapter, I will discuss Fricker's virtue ethics account (2007) and show why this is not useful for hermeneutical injustice in global health. I will clarify this by applying her account to the examples from this section. In section 3.3, I will provide an approach that is more suitable for these issues.

3. Finding a solution to hermeneutical injustice in global health

In chapter one and two, I have explained how my ecumenical account of hermeneutical injustice in global health appeals to duties from justice for both cosmopolitans and social liberals, as hermeneutical injustice can be considered both a relational and a corrective injustice. This is because, as explained by Dotson (2012), colonialization has taken away the hermeneutical resources from the indigenous population in the Global South, causing a hermeneutical gap between the Global South and the Global North, who own the dominant hermeneutical resources. Although the explanation that white ignorance is also a form of hermeneutical injustice (Dotson, 2012; Medina, 2013; Pohlhaus, 2012) is a misconception of Fricker's account (2013), hermeneutical injustice can still be considered a corrective injustice. This is because for corrective justice to take place, the original harm that is corrected for does not have occurred knowingly. This is also seen in Fricker's explanation of the virtue of hermeneutical justice: she claims it is a corrective virtue, as we will see later (2007).

Besides the negative duty not to harm hermeneutically, that has gotten attention in chapter one and two, there is also another goal of trying to reach hermeneutical justice – which can be called the positive duty of hermeneutical benefit. As Schweiger states, health is a means to achieve agency; and full epistemic agency will diminish the gap between the group with the dominant hermeneutical resources, as the Global North and the Global South will then share equal epistemic positions (2016). This will, in turn, have a positive influence on our global health, since the Global South will be better heard in what they need to achieve health.

The question left is how we should reach the goal of hermeneutical justice. Fricker (2007) has taken on a virtue ethics approach (3.1) to answer this question but as I will explain in section 3.2, these approaches will not be sufficient in the global health context. Therefore, I will argue for a participatory approach, which concentrates more on the speaker than on the individual hearer and can manage the issues of hermeneutical injustice in global health better than a virtue ethics account. I will show this using the examples given in section 2.3.

3.1 The virtue of hermeneutical justice

Fricker's solution to hermeneutical injustice is a virtue ethics account (2007), as she aims for the virtue of hermeneutical justice. In contrast to what I have done in chapter one, she does not dive deeper into the question *if we have duties following* from hermeneutical injustice and if so what

type of duties, rather than stating *that* hermeneutical injustice should be corrected simply *because* it leaves many people in an unjust situation (2003; 2007; 2013; 2015). Instead of explicitly referencing to negative or positive duties, she sketches an ideal situation in which we, through training, could develop the virtue of hermeneutical justice. This virtue entails that we develop a reflexive sensibility for the possible hermeneutical gap that might be present between the speaker and the hearer. The hearer should assess the truthfulness of his or her interpretation of what the speaker has been saying rather than assessing whether what has been said *is* true. In other words, the hearer should have an open mind and consider more interpretations with equal entitlement to be true. The virtuous hearer then sees that the speaker is struggling and tries to come at a credibility judgment of what the speaker has said *"if the attempt to articulate it were being made in a more inclusive hermeneutical climate – one without structural identity prejudice"* (Fricker, 2007, p. 170).

Although Fricker acknowledges some might struggle with developing this reflexive sensibility, she claims that the ideal virtue of hermeneutical justice does intuitively make sense and can guide the practice of the virtuous hearer. The hearer, therefore, needs to develop a more pro-active and more socially aware form of listening which is also dependent on the relationship between the hearer and the speaker. The extent to which the speaker is aware of the hearer's social identity decides how much of his or her social experience is shared with the hearer. If the practical situation allows for this, the hearer should consult other people with the same social identity as the speaker. Fricker says about this (2007, p. 2):

> Where there is a reason for the hearer to doubt the reliability of his own patterns of trust, it is rational for him to drop the presumption against acceptance, and also to assume some increased burden of seeking corroborating evidence.

Moreover, she argues that if there is no time for seeking evidence through consultation of others, the virtue of hermeneutical justice 'simply' requires an open mind and awareness of a possible hermeneutical injustice that may be present in the conversation.

Through training, the awareness of the background social theory of hermeneutical injustice might eventually be internalized which causes the hearer to eventually spontaneously act virtuously in the context of hermeneutical injustice. Eventually, as Fricker argues for the virtue of *testimonial*

justice, the virtuous hearer does not need pure argumentation or non-inferential judgments (other rational capacities) to assess a situation, his well-trained ethical sensibility makes for genuine judgments of the situation and an unreflective yet critical assessment of the speaker's word (2003). Since this sensibility combines inductive rationality with uncritical and open-minded judgments, "it honours our everyday phenomenology of spontaneity and unreflectiveness" (Fricker, 2003, p. 163).

But to get there, this sensibility needs to be trained by both collective and individual testimonial experiences. The first is a passive process, in which the hearer inherits social practices and the second is both active and passive, through the hearer's own social experiences. When they clash and the virtuous hearer finds out his individual social experiences are in tension with his passively inherited social sensibility, the virtuous hearer needs to take responsibility to adjust his or her sensibility to the new experience. Virtuous hearers will then eventually develop a right sense of trust: who can be trusted about which subjects. This will create what Fricker calls a more "inclusive hermeneutical micro-climate" between hearers and speakers (2007, p. 171): decreasing the gap in hermeneutical resources and eventually even create a situation of hermeneutical justice.

3.2 Counterarguments to the virtue of hermeneutical justice

Having explained the virtue of hermeneutical injustice, I will now discuss several counterarguments against Fricker's account by others and by myself. First, I will pay attention to her virtue ethics account more generally and later also more specifically applied to global health.

A general objection to virtue ethics accounts is argued for psychologists: we simply do not have the stable and reliable character traits that virtues would have to be (Annas, 2003). We might act bravely in one occasion, but that does not mean we *are* brave in every situation. It has been said that virtue ethics accounts overemphasize the importance of character rather than the particular circumstances, while situationist psychological research shows that the way we act depends much more on the latter than on the first. We thus lack the so-called *global* character traits that virtues should be (Annas, 2003).

These situationist objections can also be made against Fricker's virtue ethics account. If we do not seem to have global virtues that are applicable in different situations, how are we able to develop the virtue of hermeneutical justice? Some have argued that we might still have *local* virtues, meaning that our virtuous acting is supported by particular situations (Doris, 1998). For

example, it has been shown that not being in a rush supports us to act helpfully (Annas, 2003; Doris, 1998). Doris (1998) seems to argue that being virtuous thus requires avoiding situations in which we do not act virtuously – so, make sure you are never in a rush – while Annas (2003) states that exactly through experiencing these new situations we learn how to expand our local virtue to other situations. So, when taking on Annas' view, we could claim that through experiencing different situations of hermeneutical injustice we would develop the trait of hermeneutical justice. But, also mentioned by Fricker, it seems already quite difficult to both *recognize* a situation of hermeneutical injustice and *have* a reflexive sensitivity (2007). The virtue of hermeneutical justice requires both recognizing a hermeneutical injustice and acting virtuously in it. This is different from a much clearer situation such as when someone in pain needs help (Annas, 2003). Hermeneutical injustice is a complex phenomenon, which requires the virtuous hearer to look further than the actual conversation taking place – taking into account the structural character of the issue – which turns Fricker's account into a demanding solution. Even if we agree that hermeneutical justice might be a *local* virtue, meaning that we might only be able to act on the virtue in particular situations, it is already difficult to recognize these particular situations in the first place, let alone act on them.

Moreover, the fact that Fricker states that hermeneutical injustice does not take place willingly and thus no one is to blame for it, is mentioned as an objection by Sherman (2016) to the virtue of hermeneutical justice. Because if no one is being aware of his or her vicious acting, how should we then regard the virtue of hermeneutical injustice? It seems that the virtue consists of a combination of *recognizing a situation of hermeneutical injustice*, in which the hearer is not to blame for his 'vicious' behaviour as well as *developing the complex virtue of hermeneutical justice itself*, which needs to be corrective to the vicious behaviour of the previously unaware hearer. Thus, the virtue of hermeneutical justice seems very complicated and different from 'normal' virtues. We are not 'simply' dealing with the vice of dishonesty, for example, which is easily recognizable and blameworthy and of which there is a clearer view of what the virtue of honesty entails (Sherman, 2016).

Fricker is indeed aware of this complexity as she mentions several issues when describing this virtue (2007). She states that the virtuous hearer might still be hindered by his or her own social identity which might cause the speaker to share less information on his or her social experiences. Instead of bringing the hearer and the speaker closer to each other, this might even widen the gap

in hermeneutical resources. To avoid this from happening, the virtuous hearer should consult others with similar social identities to the speaker. In my opinion, this seems quite demanding for an everyday, spontaneous conversation in which and for which the virtue of hermeneutical justice should be developed. This is also mentioned by Fricker, who admits that in practice, the hearer might be virtuous but still lacks time to what I have mentioned before, 'look further than' or 'listen through' the conversation (2007). Therefore, she decreases the virtue's demandingness by stating that in situations of time constraint, being virtuous might only mean reserving judgment and keeping an open mind to the speaker's words. This, while at first, she claims the virtue of hermeneutical injustice always to be corrective: it requires not just some sort of immunity towards prejudices, but it also entails active monitoring of the influence of these prejudices on the hearer's judgments (2007). To me, this seems contradictory. Moreover, I think both interpretations of the virtue of hermeneutical justice yield complications: the first being too demanding for the individual hearer, the latter being insufficient to combat hermeneutical injustice on a global scale, to which I am trying to find a solution.

Another problem with the virtue of epistemic justice in general, which might be more applicable to testimonial injustice but still relevant for my case is that Fricker argues that to judge the trustworthiness of speakers the virtuous hearer needs cultural *stereotypes* of intellectual authority to assess whether the characteristics of intellectual authority are present in the speaker. When these stereotypes are empirically unfounded, the virtuous hearer runs the risk of having a defective sensibility, she claims. Then, in my opinion, the prejudices that Fricker wants to avoid are rather enforced. She states that "stereotypes informing testimonial exchange will tend to imitate relations of social power at large in the society" (2003, p. 164). In my interpretation, this means that, for example, a hearer thinks of white, middle-aged men as having intellectual authority, and tries to look for their characteristics in conversations with speakers in general. So, a hearer could think that speaking loudly is a sign of intellectual authority when his or her stereotype of intellectual authority is a white, middle-aged man who speaks loudly. A speaker who speaks quietly, then, is not attributed the same credibility, while the whole stereotype might be empirically unfounded. This shows the uncertainty whether we can, even when striving to be virtuous, embrace the 'right' stereotypes and let go of prejudices that cause both testimonial and hermeneutical injustice in the first place.

All these hindrances seem to make the road to hermeneutical justice long and complicated. Fricker does acknowledge this difficulty of her theory and virtue ethics in general; she thinks it will in practice be an imprecise job but, as mentioned, claims the ideal will feel intuitively right to guide this practice. This reference to intuition is interesting, as she, in a different text, emphasises that epistemic injustice needs attention for it to appear to us clearly (Fricker, 2015). In my view, the fact that we have to go back to our intuition to become virtuous seems not to hold in a global setting: intuitively we would have already changed our hermeneutical practices. If we are now still intuitively unaware of the non-inclusive hermeneutical climate, will we be intuitively susceptible to the virtue of hermeneutical injustice?

The final two counterarguments are, in my opinion, the most pressing and relevant for hermeneutical injustice in global health. The first is that Fricker's account concentrates too much on *individual* virtue. She is aware that relying on the individual hearer might not be enough for a structural problem and thus also aims for the collective exercise of the virtue. Still, her focus is on individual change rather than a change of structures. As she also admits (2007, p. 25):

> From the point of view of social change, this may be but a drop in the ocean; still, from the point of view of the individual hearer's virtue, not to mention the individual speaker's experience of their exchange, it is justice enough.

This critique has also been mentioned by Anderson (2012) who highlights the need for epistemic justice *as a virtue of social institutions* next to individual virtue. She does acknowledge the importance of an analysis of social justice from a relational paradigm and emphasizes the description of hermeneutical injustice as a great starting point to analyse the harmful global effects of individual distributive transactions. But rather than focusing on an individual solution, she moves to a more structural approach, namely the virtue of epistemic justice of social *institutions,* also since the focus on individual virtue to remedy structural injustices is, she claims, mostly a distributive strategy rather than a relational one. Individuals should not be given the responsibility, she claims, to cope with problems that are generated by structures of which it is difficult to assess their global effects. Moreover, she confirms the earlier mentioned argument that an individual virtue ethics account might be too demanding as she claims "it is hard for individuals to keep up the constant vigilance needed for the practice of virtue to sustain its good effects over time"

(Anderson, 2012, p. 164). According to her, institutions also have more power to correct issues individuals lack power for. Unfortunately, she does not give an exact explanation of what her account of the institutional virtue of hermeneutical justice would look like. Moreover, by not elaborating on this virtue, she is not able to take away some of the counterarguments made on Fricker's account. As the individual virtue already yields problems of complexity and contradictions, this seems to be an even bigger problem for institutions. How are institutions going to train their unreflective sensibility? Whom are they going to consult to become aware of the social identities of the speakers?

Finally, both authors seem to have an eye for the hearer only, whether individuals or institutions, while they do not take into account how the speaker can be involved in the solution. While the problem, after all, is unequal hermeneutical *participation*. Therefore, we need a participatory approach, in which the speakers are rightfully included in the hermeneutical climate. I will explain this approach in the final section of this thesis. Here, I will also zoom in more specifically on the examples given in 2.3.1 and 2.3.2 to show why a virtue ethics account fails and a participatory approach would be more suitable to combat hermeneutical injustice in global health.

3.3 A participatory approach to combat hermeneutical injustice

As I have mentioned various issues concerning the virtue of hermeneutical justice, I want to describe a method that seems more suitable to solve hermeneutical injustice in global health. This is a participatory approach, which is described by Blacksher (2012). Blacksher's account is not explicitly concentrated on hermeneutical injustice in *global* health, but rather more generally, on social justice in *public* health. Therefore, I will use this section to describe how this approach would work out if we apply it specifically to hermeneutical injustice in global health, by using the examples sketched in section 2.3.

Blacksher (2012), a relational egalitarian, criticizes biomedical health policies for not devoting sufficient attention to the structural aspects of health inequalities and for being only helpful to those who have the resources to seek medical advice and treatment. She aims for a group-based analysis and intervention that responds to the contexts in which people grow up, live and work. Still, she claims, even policies based on groups can benefit some groups more than others, as they run a risk of 'misrecognizing' certain groups. An example that Blacksher (2012, p. 323) gives is that of health research in which low-income urban women claimed that physical security,

street and sidewalk lighting and cleanliness were more important barriers to physical activity while the researchers hypothesized the biggest barrier being the salience of recreational activities. Moreover, she claims that this misrecognition of for example poor people can contribute to a continuous misperception of them being deficient or needy, which re-enforces health inequalities.

To overcome these relational inequalities in public health, she argues for a *participatory approach* in decisions about public health policy which she calls 'participatory parity in health'. Such an approach is meant to involve marginalised groups to decrease the chance of misrecognition or disrespect. Translated to the case of hermeneutical injustice, this would mean that the 'speakers' would become agents of policy, rather than merely recipients. Participatory parity, according to Blacksher (2012), has both democratic and transformative intentions. Democratic intentions make the 'speakers' agents of public health action, rather than simply 'victims of pathology'; transformative intentions are aimed at reformulating the underlying harmful social structures and processes. Therefore, a participatory approach is not simply meant to create participation at the implementation stage of health policies, but at an earlier stage: that of formulating the policy.

As you can see, the participatory approach is much more focused on the speaker than on the hearer. I have mentioned before that this is, among other things, one of the issues of the approaches of Fricker (2007) and Anderson (2012). Even though Anderson's approach seems more suitable to combat hermeneutical injustice in global health since it focuses on institutions rather than on individuals, it still does not pay sufficient attention to the most important player in hermeneutical injustice: the speaker.

How would a participatory approach apply specifically to global health? Participatory approaches in global health are not new and an important feature of many declarations and programs of global health (Blacksher, 2012). But, as Blacksher argues, they do not always include the democratic and transformative intentions that participatory parity should have. The focus of participatory approaches, namely, has mostly been on efficiency, as promoted by distributive theories who tend to look at the outcomes of a policy. And although participatory approaches might indeed be efficient, the focus should be on the expressive dimension: the way in which the approaches show respect and recognition for the speakers. This should be the main focus, in order to cope successfully with hermeneutical injustice in global health, as this is a relational issue rather than a distributive one.

So, participatory approaches should be able to combat hermeneutical injustice in global health, namely by ensuring equal hermeneutical participation of the Global South in the global health debate. I am aware that a participatory approach might not be able to take away structural inequality and structural prejudice, the other two criteria of hermeneutical injustice, but since all three criteria have to be present to speak of a situation of hermeneutical injustice taking away one would suffice as a solution. By showing how this works out in practice, I will specifically look at the examples I gave in section 2.3, namely paternalism in and medicalization of global health.

3.3.1 A participatory approach for paternalism in global health

A participatory approach for paternalism in global health would not yield the issues of Fricker's (2007) or Anderson's (2012) virtue ethics account, since it focuses on the speaker rather than on the hearer, which is needed to take away the unequal hermeneutical participation that is present in paternalism in global health. Also, paternalism is based on a paternalistic prejudice, meaning that the hearer thinks of the speaker as nice, but incompetent, so it is unlikely that he or she would become aware of hermeneutical injustice that is needed for the virtue of hermeneutical justice. Becoming aware of prejudices that at first instance seem 'positive', as probably the hearer judges his or her thought about the speaker to be, seems much more complicated than becoming aware of prejudices that are more prominently 'negative'. So, Sherman's critique (2016), that a situation of hermeneutical injustice might not be as easily recognized by the hearer, also applies here.

A participatory approach would be a better strategy for paternalism in global health. This is because, most importantly, a participatory approach for paternalism in global health is more likely to stop paternalism altogether, for it cannot be called paternalistic anymore when the targeted populations are consulted and asked consent for global health policies. This would have to mean, though, that the beneficiaries in the Global South are not participating in a 'shallow' way, as described by Barnett (2012), only in the implementation stage, but there should be 'strong' participation in which the beneficiaries are participating in the formulation stage. This will provide equal hermeneutical participation and *express* respect to the communities that the policies are targeted at. So, a participatory approach will take into account the expressive considerations of paternalism. Providing a more equal hermeneutical participation might even have consequences for the other two criteria of hermeneutical injustice; it could lead to a better understanding of both parties and therefore diminish the global paternalistic prejudice.

Specifically applied to double ethical review in global health research, the example I gave of paternalism in global health, a participatory approach would invite the Global South to be an equal partner in the hermeneutical discourse: meaning researchers from the Global North would become to see how single review by the Global South would suffice. This would show respect and recognition, which would lead to full epistemic agency of the Global South. So, not only does a participatory approach meet the negative duty of hermeneutical injustice, it also seems able to meet the positive duty of hermeneutical benefit. This will have a positive influence on global health, as closing the hermeneutical gap will bring more cooperation and acknowledgement of ethical review in the Global South, promoting the goals of ethical research by the Global South's own standards.

3.3.2 A participatory approach for the medicalization of global health

For the medicalization of global health, the same advantages of a participatory approach are present. Participation, specifically in formulating health policies, can prevent medicalization from happening in the first place. Would, for example, India have been included in the formulation of the policy for malnutrition, technological solutions such as ready-to-use foods would not have been chosen since it is a more efficient and less expensive option for India. Furthermore, and even more important for such a relational injustice, is that participation of the Global South in health policies shows respect – an expressive consideration – for India's own solutions to malnutrition and it allows for acknowledging the structural issue that malnutrition is. Simply providing ready-to-use foods without the participation of the Global South in this policy denies showing an actual interest in combatting the structural factors that *cause* malnutrition in the first place. Although I am not claiming here that a participatory approach can do all that, it is at least a starting point for closing the hermeneutical gap and therefore decreasing the chance of medicalization in global health. Providing the Global South participation in formulating health policies gives way to their interpretation of their own social experiences and a more hermeneutically just situation. This would lead to a shift in focus from the technological, medicalized solutions to an actual analysis of the structural problems that global health problems usually are. Combatting hermeneutical injustice, a relational and structural problem, will lead to a more inclusive hermeneutical climate in global health. Therefore, hermeneutical justice can be the starting point for the fight against other structural injustices, making it a very relevant concept.

Conclusion

This thesis has contributed to the debate in global health by providing insight from the relational paradigm to the traditionally distributive discussion. I have analysed the concept of hermeneutical injustice, described by Fricker mostly on a local scale, and investigated its presence in global health between the Global North and the Global South. I have concluded that a situation of hermeneutical injustice has to meet three criteria: there has to be (1) unequal hermeneutical participation, against a background of (2) structural prejudice and (3) structural inequality. I have specifically focused on this latter criterion, a concept described by Young and analysed the connection between hermeneutical injustice and structural inequality to show how they are in many ways interconnected. These three criteria can be useful, I have shown, to distinguish situations of epistemic bad luck and epistemic isolation from actual hermeneutical injustice.

To see how hermeneutical injustice specifically plays out in global health, I have given two examples. Paternalism in global health, seen in double ethical review in global health research, and the medicalization of global health, shown in the treatment of malnutrition, are illustrative of how the Global South is suffering a hermeneutical injustice in global health. I have shown how these examples meet the aforementioned criteria, as the Global South is unequally hermeneutically participating, the Global North has structural prejudice of the Global South and there is structural inequality between the Global North and the Global South.

As a background to this analysis, I analysed the value of health and gave definitions of individual and global health. Moreover, I discussed different (distributive) positions in the global health debate and the critique of relational egalitarians on the traditional distributive debate in global health. To provide a basis for the solution of hermeneutical injustice I argued that my account of hermeneutical injustice is ecumenical, appealing to those who aim for global duties from justice, whether cosmopolitans or social liberals arguing for corrective justice.

Finally, I explained Fricker's virtue ethics account and showed how it yields too many problems to solve hermeneutical injustice in global health. Instead, I have advocated for a participatory approach, specifically applied to the examples of paternalism and medicalization of global health, by showing how it ensures equal hermeneutical participation.

Having come to the end of this thesis, I am hopeful that my analysis of hermeneutical injustice in global health has provided a contribution to the global health debate, having shown the relevancy and urgency of the concept and, moreover, provided a normative solution.

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