Knowledge, Power, and International Development: Beyond Critique

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25 September 2021

This thesis is submitted in partial fulfilment of the requirements of Oxford Brookes University for the degree of Doctor of Philosophy on the basis of published work.

Abstract

Knowledge and power are important in international development. Michel Foucault, a theorist of power, conceptualised knowledge and power as being in a dynamic and reciprocal relationship (Foucault, 1980 p52). This thesis explores the relationship between knowledge and power, focusing on my published work on Civil Registration and Vital Statistics (CRVS) as part of the international development agenda.

From an anthropological perspective, CRVS documents such as birth and death registrations represent a mutual relationship between nation-states and citizens, conferring rights and obligations (Gray and Bedford, 2016; Simpson, 2018). Nation-states use birth and death data from CRVS systems to quantify and classify life (Hanna *et al.*, 2013). These data and analyses are also critical for international development strategies such as the Sustainable Development Goals (SDGs) (World Bank, 2017).

However, despite their national and international importance, CRVS systems have been neglected by the international development community over many decades, resulting in a 'scandal of invisibility' (Abouzahr *et al*., 2007; Setel *et al*., 2007). As a result, the births and deaths of many people in developing countries are never officially recognised, rendering them invisible in international development policy and practice (World Bank WHO, 2014). This neglect has particularly affected global health as an international development agenda. However, between 2010 and 2018, my published work - including the publication of new global and regional strategies for CRVS - contributed to a significant shift in global development policy towards CRVS after these decades of neglect.

This thesis focuses on how development documents are established and negotiated through cross-agency international development partnerships, offering fresh ethnographic insights into how development actors seek to use power and knowledge in the social processes of development. Going beyond the customary anthropological critique of international development (Venkatesan and Yarrow, 2012), this thesis considers the contemporary relevance of Foucault's theories about power and knowledge to international development policy and practice.

Acknowledgements

This thesis would not have been possible without the excellent leadership and guidance of my supervisors, Professor Jeremy MacClancy and Dr Jennifer Diggins, and the love and support of my husband and children, who have been my inspiration. In addition, many friends and colleagues have contributed to my body of published work and are recalled fondly throughout this document.

Word Counts

Abstract	300 words
Thesis (including document overview in Annex)	24,050 words
Published Work	70,000 words

Glossary

CRVS	Civil Registration and Vital Statistics
GFF	Global Financing Facility
ICD	International Classification of Disease
MDGs	Millennium Development Goals
SDGs	Sustainable Development Goals
UN	United Nations
WHO	World Health Organization

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Introduction

Knowledge and power are central to understanding international development. According to Michel Foucault, a theorist of power, there is a dynamic and reciprocal relationship between knowledge and power, with knowledge producing power and power relying on knowledge (Foucault, 1980 p52). This thesis explores the relationship between knowledge and power during a period of international policy development for Civil Registration and Vital Statistics (CRVS). CRVS systems record vital events in a population, such as births, deaths, and marriages. For individuals, registration of births, deaths, and marriages creates social identities, confers fundamental rights such as citizenship, and enables access to state benefits and services (Fuhrer and Eichner, 2015). For both nation-states and international agencies, CRVS data helps inform health and other policies by enabling them to understand the characteristics and dynamics within a population (Abouzahr et al., 2007). At the international level, CRVS is now an individual goal within the Sustainable Development Goals (SDGs) and underpins multiple other health and development goals (World Bank, 2017).

However, despite their national and international importance, CRVS systems have been neglected by the international development community over many decades (Abouzahr et al., 2007). As a result, CRVS systems in many developing countries are weak, with around one-quarter of all births not registered (Jackson et al., 2018 in Annex A.10). In addition, most deaths are never recorded at all (Abouzahr et al., 2007). This lack of birth and death registration results in a 'scandal of invisibility' where the critical events in people's lives are never legally recorded, leaving individuals unseen in policy and practice (Setel et al., 2007). For example, CRVS data is key to quantifying the disadvantages faced by many Indigenous Australians. However, historical mistrust of government results in under-registration of births, rendering many Indigenous people effectively invisible to the state (Queensland Ombudsman, 2018 p4). This invisibility affects international development policy and practices at many levels. For example, towards the end of the Millennium Development Goals (MDGs), the lack of CRVS data meant targets to reduce maternal, newborn and child deaths were hard to measure (Harris Requejo *et al*., 2015). Likewise, it was impossible to accurately count deaths during the Ebola outbreak in Africa in 2014-2015, impacting response and strategy at national, regional, and international levels (UNECA 2015).

Between 2010 and 2018, a significant shift occurred in international development policy towards CRVS, with the establishment of a global CRVS plan and investment of $100m in a new financing facility (Canada IDRC, 2018 in Annex A.9). My published work (Table 1 below) contributed significantly to this shift, building empirical observations from fieldwork to influence the modernisation of global policies and actions.

Table 1: Body of Published Work

Annex	**Reference**
A.1	Schmider, A. (2010). *Advocating for civil registration: guide to developing a business case for civil registration*. University of Queensland, Australia
A.2	University of Queensland (2012a). *Country Report: Mongolia Civil registration and vital statistics assessment and health information systems training*. University of Queensland, Australia University of Queensland (2012b). *Country Report: Philippines CRVS improvement and strategic planning*. University of Queensland, Australia University of Queensland. (2012c). *Country Report: Cambodia CRVS improvement and strategic planning.* August 2012. University of Queensland, Australia
A.3 (Module 8 only)	World Health Organization (2012). *Civil Registration and Vital Statistics Resource Kit*. WHO Geneva
A.4	World Health Organization (2013a). *Strengthening Systems through Innovative Approaches in the Health Sector: Guiding Principles*. WHO Geneva
A.5 (CRVS progress chapters)	World Health Organization (2013). *Translating Recommendations into Action: Report on Progress Towards Implementing the CoIA Recommendations.* WHO Geneva World Health Organization (2014) *Implementing the Commission on Information and Accountability Recommendations: 2014 Progress Report.* WHO Geneva World Health Organization (2015) I*mplementing the Commission on Information and Accountability Recommendations: 2015 Progress Report.* WHO Geneva
A.6	World Bank-World Health Organization (2014). *Global Scaling Up CRVS Plan 2015-2030.* World Bank, Washington.
A.7	WHO, UNECA & ASSD (2015). *Improving Mortality Statistics in Africa: Technical Strategy 2015 – 2020*. UNECA Ethiopia.
A.8	Boerma, T., Harrison, J., Jakob, R., Mathers, C., Schmider, A., Weber, S. (2016). 'Revising the ICD: Explaining the WHO approach'. *The Lancet* Vol 388 issue 10059
A.9	Canada International Development and Research Centre. (2018). *Global State of CRVS*. IDRC, Canada.
A.10	Jackson, D., Wenz, K., Muniz, M., Abouzahr, C., Schmider, A., Braschi, M., Kassam, N., Diaz, T., Mwamba, R., Setel, P., Mills, S. (2018). 'Civil registration and vital statistics in health systems'. *Bulletin of the World Health Organization* 2018:96

The challenges of cross-agency international development work are rarely documented. This thesis focuses on how development documents are negotiated through cross-agency international development partnerships, offering fresh ethnographic insights into how development actors seek to use power and knowledge in the social processes of development. It explores how development actors use knowledge and power as part of the social processes of development, especially in global health, where normative documents are used to persuade and influence organisational and global interests (Shiffman, 2015). As explored in this thesis, the documents submitted for this PhD were instrumental in securing and shaping new inter-agency partnerships during international policy windows at the end of the MDGs and after the Ebola outbreak in West Africa. My published work established new social processes that included a greater range of voices, including the voices of colleagues in developing countries whose expertise was often excluded from international CRVS discourse.

Going beyond the customary anthropological critique of international development (Venkatesan and Yarrow, 2012), this thesis further considers the contemporary relevance of Foucault's theories about power and knowledge to international development policy and practice. As such, this thesis offers fresh ethnographic insights into *how* and *why* development actors seek to use power and knowledge within the social processes of development.

Starting with an interdisciplinary review spanning the global health and anthropology literature (Chapter 1), this thesis outlines its use of the analytical autoethnographic method (Chapter 2) before examining knowledge development and the social processes of partnership across my body of published work (Chapters 3 and 4). This thesis then links empirical observations to theoretical frameworks in Chapter 5, considering the contemporary relevance of Foucault's theories about power and knowledge for international development policy and practice, going 'beyond critique' (Venkatesan and Yarrow, 2012).

1. Interdisciplinary Literature Review

This chapter establishes CRVS as part of the international development agenda, specifically, its relationship to health as a development agenda ('global health'). It then explores the anthropology literature for insights into the development world's social processes, layers, and contradictions (Crewe and Axelby, 2013). Finally, it includes specific attention to the work of Michel Foucault, which provides a backdrop for later sections of this thesis.

CRVS and Global Health – An Integral Relationship

In the 21st Century, CRVS systems are crucial for international development strategies, with CRVS data essential for understanding progress towards many global health goals (Mahapatra *et al*., 2007; World Bank, 2017). CRVS data are used to analyse multiple health and international development targets within the MDGs and their successor, the SDGs (World Bank, 2017). The SDGs identify multiple international development targets for which CRVS data are used, including health targets and other targets such as legal identity (Table 2 below) (World Bank, 2017).

However, international neglect of CRVS over many decades (Abouzahr *et al*., 2007) meant that many global health goals could not be monitored (Mahapatra *et al*., 2007); and there was little evidence to demonstrate any reduction in mortality or improvement in life expectancy (Setel *et al*., 2007 p1569). The sprawling health development landscape has affected the focus on CRVS (Yates-Doerr and Maes, 2019, p.2). 'Global health' is a landscape that comprises a broad range of actors, institutions and programmes which seek to influence international health concerns (McInnes, 2020); described as a juggernaut (Pigg, 2013).

The most internationally recognized global health actor is the World Health Organization (WHO), formed in 1948 as a specialist UN agency (Harman, 2012). The WHO seeks to achieve the highest attainable standard of health as a fundamental human right (WHO, in Fidler, 2009). It does this by using its epistemic authority (Stone, 2020) to offer normative capacity to its Member States. The publication of strategies and plans, health standards and research are essential to its authority (Khazatzadeh-Mahani *et al*., 2020).

Table 2: SDGs - Targets and Indicators related to CRVS

SDG Targets and Indicators Related to Civil Registration and Vital Statistics

SDG Target	Indicators for Monitoring Progress
16.9 By 2030, provide legal identity for all, including birth registration	16.19.1 Proportion of children under 5 years whose births have been registered with a civil authority, by age
17.18 By 2020… increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts	17.18.1 Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics
17.19 By 2030… support statistical capacity building in countries	17.19.2 Proportion of countries that have conducted at least one population and housing census in the last 10 years and have achieved 100 percent birth registration and 80 percent death registration

SDG Targets Requiring Mortality and Cause-of-Death Data

Target	Definition
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, waterborne diseases, and other communicable diseases
3.4	By 2030, reduce premature mortality from non-communicable diseases by one-third through prevention and treatment and promote mental health and well-being
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination
11.5	By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations
16.1	Significantly reduce all forms of violence and related death rates everywhere

Source: *World Bank, 2017*

However, many new actors have emerged to contest the authority of the WHO role in the global health landscape, with the WHO facing multiple challenges to its legitimacy from other global health actors (Khazatzadeh-Mahani *et al*., 2020). The World Bank, UN Population Fund, UNICEF, and the UN Development Programme have all secured roles within global health agendas, especially since the launch of the MDGs. Other large agencies have emerged into the global health landscape, for example, partnerships such as the Global Fund and GAVI Vaccine Alliance (Harman, 2012). In addition, private philanthropic actors such as the Bill and Melinda Gates Foundation have played an increasing role in global health interventions, research, and development (Harman, 2012; Rushton and Williams, 2011). The health agendas of these actors often overlap with that of the WHO (Harman, 2012), and they often publish their own global health strategies, plans and research (Smith and Schiffman, 2020).

As a result, 'global health' now comprises numerous health actors, a confusing array of initiatives and programs, competing and overlapping governance structures, and complicated lines of responsibility (Youde, 2013). This complexity is reflected in international development interests for CRVS. For example, responsibility for norms and standards is shared by WHO and the UN Statistics Division

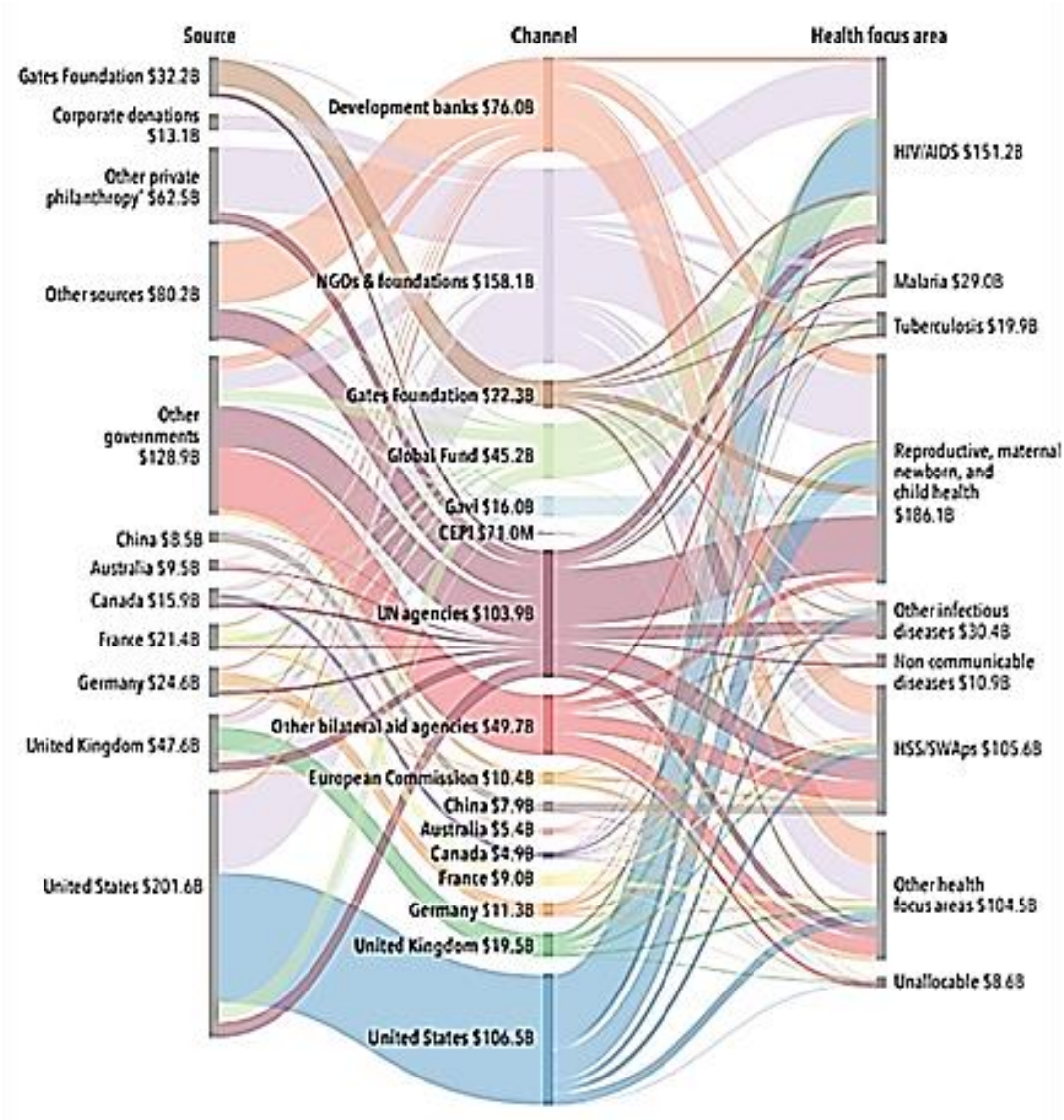
(Abouzahr and Boerma, 2005). However, programme responsibility is shared more broadly across regional agencies such as the UN regional commission, with many other international and private sector actors involved (Canada IDRC 2018 in Annex A.9).

Global health actors must now interact more pluralistically than hierarchically in an environment described as either vibrant (Frenk and Moon, 2013) or chaotic and lacking authority (Harman and Rushton, 2014). Fidler describes global health as 'open-source anarchy', a landscape where actors resist governance approaches that restrict their freedom of action, thereby rendering health as an international development concern ineffective (Fidler, 2007, p1). Furthermore, with blurred boundaries and few accountability mechanisms, global health policymakers increasingly compete for authority (Stone, 2020). Therefore, discussion about governance is a critical theme in the global health literature (Frenk and Moon, 2013; Harman and Rushton, 2014; McInnes and Lee, 2012).

Since the turn of the 21st century, an influx of development finance has influenced the global health landscape (Fidler, 2007; Harman, 2012; Rushton and Williams, 2011; Youde, 2013). Analysis of the flow of funding for global health shows how many relationships are now constructed hierarchically between actors (Figure 1, below). The diagram shows the contemporary relationships between global health actors. For example, donors channel development finance through global health agencies, including development banks, UN agencies, government, and non-government organisations, towards global health targets articulated in the SDGs. In addition, donors such as the United States provide most of their funding to their own bilateral development activities. Global health agencies are the 'channels' of this finance. As shown in the diagram, many global health agencies appear to be working on the same development agenda. Rather than serving as a framework for policy communities, seen from a financing viewpoint, the multiple health targets under the SDGs seem complicated both by financing and global health actors.

Therefore, financing is a powerful influencing instrument in this environment. Donors exercise the 'power of the purse' (McInnes, 2020 p274) by attaching funding conditions requiring recipients to spend funds in specific ways (Youde, 2013), providing greater amounts of funding for global health issues through new financing initiatives at development banks such as the World Bank Global Fund or GAVI, as shown in Figure 1 (Hanrieder, 2020; Harman, 2012; World Bank, 2015). Some authors argue that donors deliberately use this funding to create and strengthen actors such as the World Bank, GAVI Alliance and Global Fund or weaken global health actors such as the WHO (McInnes and Lee, 2012; McInnes *et al*., 2020; Youde, 2013). In this complex environment, McInnes and Lee (2012) argue that there are open and unanswered questions about what power is, who holds it, and how it is exercised and wielded.

Figure 1: Flows of Development Finance for Health 1990-2018



Source: *University of Washington, 2018*

Knowledge plays a vital role in this complex environment. The WHO was created with a knowledge-oriented function to use its scientific expertise to publish global health standards and research (Khazatzadeh-Mahani *et al*., 2020). As such, WHO is a science-defined epistocracy with agreed authority across the global health landscape, producing knowledge through its epistemic communities. The very existence of the WHO creates a link between knowledge and power in global and national decision-making processes (Stone, 2020 p52). However, there are a growing number of knowledge experts and epistocracies in other agencies in the global health landscape. In addition, communities or partnerships

may network for knowledge production, seeking to entrench policy paradigms and related epistocracies (Stone, 2020).

This relationship between power and knowledge appears important, yet understudied, in global health. Shiffman (2015) describes global health in practice as a field of power relations where actors use knowledge and expertise to gain influence and pursue career, organisational and national interests. For example, the World Bank has created substantial in-house knowledge and expertise and now regards itself as a 'knowledge bank' (Stone, 2020). The Bank's 1993 Report *Investing in Health* published new knowledge about financing for health, establishing a new role for the Bank in global health, an historically significant move (Benetar *et al*., 2020; Kenny, 2015; Sparke, 2020). However, the range of actors creates contestation over policy definitions, priorities, and strategies, limiting the effectiveness of global health policies (Smith and Schiffman, 2020).

In this environment, Schiffman and Smith argue that successful negotiation by development actors within knowledge development processes is key to determining the success or failure of their ideas and initiatives (2007). For example, 'policy windows' are identified as periods where worldwide conditions align favourably for policy improvement in global health. These windows offer the opportunity for global health actors to produce knowledge to convince political leaders to act and allowing networks to negotiate and realign their ideas around complex health issues (Schiffman and Smith, 2007). These partnerships and networks may be *formally constituted* as mandated actors or *informally constituted* as 'actor constellations' (Rushton and Williams, 2011). Documents are essential vehicles for these partnerships. Once a new policy idea is incorporated into global health documentation, it is accepted as the cognitive architecture (Schiffman and Smith, 2007).

However, power is not explored in depth in the global health literature. The global health literature *describes* actors and institutions rather than their relationships or social development processes; therefore, power is implicit rather than explicit. Scholars in global health assume (rather than examine) the 'structural forces' that influence global health policy-making (Smith and Schiffman, 2020, pp336-337). The languages, theories, and institutions of the 'global north' appear to be accepted as dominating knowledge development processes (Ingram, 2020 pp89-90). There are also acknowledged gender inequalities within health processes, with women and children often having little power or presence in political processes, thus requiring 'champions' to address their issues (Smith and Schiffman 2020), with little analysis of reforming these biased processes. In contrast, anthropological theories and studies offer opportunities to study power in international development, as discussed in the following section.

Anthropological Perspectives

CRVS systems document the beginnings and endings of life. As such, anthropology takes a broad interest in CRVS from cultural, social, and political perspectives. Anthropological interest ranges from understanding normative cultural practices related to births and deaths to political debates about when life begins and ends (Kaufman and Morgan, 2005). For example, birth and death registration processes represent a reciprocal relationship between nation-states and citizens, with anthropological studies identifying how birth registration provides individuals with a vital document for employment, education, opening a bank account, accessing services and social security, and applying for an identification card, driving licence and passport (Gray and Bedford, 2016). Likewise, death registration processes confer rights and obligations on remaining family members who manage the processes for death (Simpson, 2018).

Anthropological studies have also examined the complex interplay between economic, non-economic, personal, structural, social, and cultural factors which affect a CRVS registration (Chereni, 2016; Gray and Bedford, 2016). For example, customs that prohibit naming a child at birth may delay formal birth registration. In addition, barriers to birth registration may exist where legal requirements exist to register both parents on a birth certificate, especially if a child is considered illegitimate (UN Statistics, 2019). Analysis of the beginnings and end of life can be seen as sitting at the intersections of local traditions, state imperatives, and the global reach of biomedicine (Kaufman and Morgan, 2005). Analysis of these routines has proven crucial for understanding how cultural practices associated with deaths affect health activities, for example, during the Ebola outbreak in West Africa (Grant, 2017; Stellmach et al., 2018). Anthropological studies analyse death as a period when distinctive, expert routines are practised to ensure the meaningful transition for the body, family, and community:

> *The list of ways in which bodies might be disposed of to the satisfaction of the living (and the dying) is long… It is the attempt to make sense of this mixing of social relationships, ritual practices, and metaphysical beliefs as it is found in different societies that has made the study of death such an engaging and intellectually challenging field within anthropology*. (Simpson, 2018 pp2-3)

The registration of births and deaths is also an analytical resource for nation-states. States issue a documented confirmation of a birth or death and count these events as data to quantify and classify life (Hanna *et al*., 2013). By classifying and quantifying life, Michel Foucault argued that nation-states were exercising biopower, using the basic biological features of the human species as the object of a political strategy (Foucault 2007). To Foucault, the emergence of biopower represented a shift in the focus of government intervention in populations' lives, from the use of sovereign or disciplinary power towards

making live and letting die (Taylor, 2011), for example, by increasing life expectancy and reducing mortality (Foucault, in Bertani and Fontana, 1997). Foucault focused primarily on biopower as it related to nation-states. However, these types of analyses are also used at the international level, where global strategies and targets seek to enumerate, categorise, and measure populations (Wilson, 2017) to improve lives and reduce deaths. For example, when the World Health Organization (WHO) was established in 1948, one of its first tasks was maintaining the international standard for CRVS systems which classifies population disease and deaths (WHO 1949).

Understanding Knowledge and Power in Development

Anthropological scholarship focused on international development has been fuelled by a greater understanding of the underlying social dynamics that shape this sector (Ahmed, 2006; Green, 2013). This includes attention to the relationship between power and knowledge within these social processes, a depth missing in the global health literature.

Michel Foucault's work has been crucial to analysing power and knowledge from an anthropological perspective. Foucault classified himself as an 'experimenter' rather than a theorist, and, accordingly, his work and thinking evolved (Taylor, 2011). The academic community divides his work into three phases: the *archaeological* phase, the *genealogical* phase, and a final phase from 1977 onwards, known as the *ethical* phase (Välikangas and Seeck, 2011). Each phase of work was essential to the development of Foucault's thinking on knowledge and power. For example, in his 'archaeological' phase, Foucault examined the formation of scientific knowledge and 'regimes of truth' through which scientific knowledge progresses, and human beings understand themselves (Välikangas and Seeck, 2011 p3). Although he did not explicitly name the relationship, in this phase of work, he did establish the connection between knowledge and political power (Feder, 2011; Foucault, 2009 p215).

In his second 'genealogy' phase, Foucault analysed political questions of power more specifically. For example, his work *Discipline and Punish* examined state power related to the disciplinary control of prison populations (Välikangas and Seeck, 2011). His theorising in this phase extended analysis of the use of power to institutions and society more generally (Hoffman, 2011), emphasising that power is omnipresent, interwoven and revealed in all social interactions (Lynch, 2011). Interestingly, he identified power as both productive and creative (Foucault, 1976), proposing that knowledge and power existed in a dynamic and reciprocal relationship (Lynch, 2011). Foucault introduced the expression 'power/knowledge' (Feder, 2011) as a means of articulating this relationship between these two elements, arguing that power could not be exercised without knowledge and that it was impossible for knowledge not to produce power (Foucault, 1980 p52).

In his final phase of work, Foucault explored the nature of power as a capacity exercised by one upon another (Foucault, 1982). He retained the view that power was dynamic and productive; for example, in his essay 'The Subject and Power', Foucault argued that the exercise of power was adaptive, with processes adjusted to each situation (Foucault, 1982 p345). Further, he noted that people placed in relationships of production and significance were also placed in power relations that were very complex (ibid, p327). Despite this complexity, according to Foucault, power relationships could be understood by establishing the 'system of differentiation' which permits one to act upon the actions of others; understanding the types of objectives pursued, the instrumental modes of power and the forms of institutionalization of power; and the degree of rationalization of power (*ibid* pp344-345). This final stage of Foucault's work on power also included his theories about biopower, discussed earlier in this thesis. To Foucault, disciplinary power and biopower were inextricably linked as the 'two poles around which the organization of power over life was deployed' (Foucault 1990, cited in Lynch, 2011). Foucault argued that biopower *extended* the state practices of power using knowledge to administrate the norms of a population as a whole (Taylor, 2011). Foucault's power analyses have driven critiques of development policy (Mosse, 2013), including analysis of power and political relationships in international development (Venkatesan and Yarrow, 2012). The global health literature described how actors use knowledge, expertise, and moral authority to influence and pursue career, organisational and national interests (Shiffman, 2015). However, anthropology has sought a richer understanding of how this occurs; for example, analysing how development actors create knowledge through documentation (McNeill and St Claire, 2013), use knowledge and power to shape practice (Crewe and Axelby, 2013, p43), and develop new, alternative modes of thought (Taylor, 2011).

In global health literature, 'policy windows' are periods where worldwide conditions align favourably for policy improvement, enabling networks to negotiate and realign their ideas around complex health issues (Schiffman and Smith, 2007). However, 'policy windows' from an anthropological perspective are periods of dynamism, where international bureaucracies create new relations to facilitate the relationship between knowledge and power (Billaud and Cowan, 2020) through innovation and experimentation in economic and political thought (Ingram, 2020). Green, for example, argues that ideas are brokered in a development marketplace, with documents identifying expertise and relationships (2013 p37). This type of marketplace can be visualised from the earlier diagram of the University of Washington (2018) (see Figure 1), which shows the breadth of global health agencies engaged in delivering programmes between donors and health development goals.

As discussed earlier, the WHO's very creation entrenches a knowledge hierarchy in global health, although this hierarchy is contested. Anthropological studies also examine these hierarchies at an empirical level. For example, Eyben notes that control is exerted by head offices over development professionals in-country (2013 p143). Harper examines how knowledge cements this elite hierarchy:

> *The correct mode of behaviour – that prescribed by WHO experts and implemented through the national tuberculosis programme – gazes down gradients of authority and places the burden of compliance with prescribed behaviour firmly on the shoulders of the ill…. To be 'sanitary citizens', then requires that prescribed nodes of behaviour are adopted in relation to medical epistemologies…. These behaviours are being prescribed by constellations of organizations (some state, some international), and the surveillance of the programmes of implementation are overseen by experts (myself included)* (Harper, 2013 p132).

Anthropological studies also investigate *how* power and knowledge are negotiated (Cornwall and Eade, 2010; Crewe and Axelby, 2013; Herrick, 2017). As Green observed, prominent disciplines such as economics are used to dominate the discourse of development professionals (2013 p51). Separating policy from practice (Mosse, 2013 p96), elite development professionals purposively construct problems to create legitimate spaces for intervention (Ahmed, 2006 p3).

Therefore, knowledge and power are crucial to understanding the 'social processes' of development (Mosse, 2005). Knowledge helps actors exercise agency in an environment of uneven power relations and complex layers (Crewe and Axelby, 2013). To this end, development partnerships circulate ideas and discourse (Billaud and Cowan, 2020). However, these partnerships may be only temporary or arrangements of convenience (Okeke, 2018), with competition between development actors over ideas (Billaud and Cowan, 2020). For example, Eyben describes internal competition over ideas within development agencies, describing the competition between development agendas 'back home' and development practice in targeted countries (2013 p157). Tucker (2014) analyses how development discourse is shaped by *external* power dynamics between development agencies, with international agencies exercising power over non-government organizations in development dialogue, encouraging conformity to dominant development norms.

Development Documents: Chronicling Knowledge and Power

Documents are essential in the global health landscape, codifying ideas, knowledge, and beliefs about what should exist in the world (Smith and Schiffman, 2020). Once a new policy idea is incorporated into global health documentation, it is accepted as the cognitive architecture (Schiffman and Smith, 2007). In addition, documents such as plans, strategies and reviews are considered crucial for the stability of these epistemic framings (Mosse, 2005 in Harper, 2013). Documents also record targeted progress in health (Ingram, 2020), with 'huge amounts of work and effort' undertaken to analyse framings of health against corresponding policy frameworks, with documents used to characterise health through country and epidemiological profiles charting the distribution of disease and illness (Harper, 2013 p129).

Ethnographic studies examine the social nature of policy production practices (Fechter, 2011). As Green notes, documentary practices are social practices, with documents produced by teams and reworked through a hierarchy within the broader social contexts of development projects and programmes (2013 p41). However, as Mosse points out, little attention has been paid to the social and institutional context in which policy ideas are formulated and, therefore, the positions and interests of professional groups in developing those ideas and documents (2013, p81).

Documents chronicle the relationship between knowledge and power within these social processes. For example, development professionals manipulate text into documents to nurture social relationships inside and outside a development agency (Green, 2013 p39), seeking to influence the international system (Crewe and Axelby, 2013). Documents may explain coalitions around policy choices at a point in time (Green, 2013) or represent the outcome of power or conformance to official or epistemic narratives (Mosse, 2013). Documents may also reveal bias and inequality in policy processes; for example, how politics and power have marginalised local knowledge (Ahmed, 2006) or how languages, theories, and institutions of the global north are embedded (Ingram, 2020). For example, Escobar argued that rich countries were powerful and dominant in development discourse and entrenched their economic knowledge in documents using 'experts' in international institutions, including the UN and international lending institutions (1995, p41). The use of experts and dominant knowledge paradigms may entrench powerful models and frameworks which are promoted as universally applicable (Crewe and Axelby, 2013 p7). However, these global models and frameworks can fail in practice. For example, science and technologies promoted by agencies and professionals from the global north are often retooled and relocated to 'improve' life in other countries. The extensive resources for these scientific and technological projects contrast with poor resourcing and literacy in local health systems (Kelly, 2012 p70-71).

Summary

The interdisciplinary literature review considers literature focused on power and knowledge from a global health and anthropological perspective. The global health literature leaves open questions about the social processes of development and the relationship between knowledge and power. In contrast, anthropology literature is rich with analysis of the relationships between knowledge and power in international development. This thesis seeks a deeper understanding of the relationships between knowledge and power within the social processes for global health. The following section outlines the methodology for this analysis.

2. Methodology

Disciplinary Positioning

This thesis sets out to analyse my body of published work and its partnerships for their contribution to this renewal of CRVS as a development agenda. Since my work was part of a broader multidisciplinary agenda, it is essential first to position this work within the field of anthropology. There has been a longstanding debate within academic anthropology about its disciplinary relationship to international development. Gow (2002) describes this as a 'family dispute' between development anthropologists and academic anthropologists about the role and orientation of anthropology in international development. Escobar, for example, criticized 'development anthropologists' as having a trusting acceptance of prevailing development paradigms (Escobar, 1995; Gow, 2002). On the other hand, critical anthropologists such as Escobar have also been criticised by others in the field as relentlessly disparaging of international development (Jensen and Winthereik, 2012); diminishing its vision of a better or more just future; and undermining the active use of anthropological knowledge to transform both academic and development practice (Venkatesan and Yarrow, 2012). By focusing only on deconstruction and criticism, Green argues that anthropology has missed opportunities to contribute to global reordering processes, leaving disciplines such as economics to promote pro-market policies successfully (2013 p51).

A more recent call has been made for an anthropological approach that moves 'beyond critique' (Venkatesan and Yarrow, 2012). This movement argues that contemporary anthropology could better understand how ideas of 'development' can be integrated into the social processes and relationships, illuminating the moral and social worlds in which development ideas are made meaningful. Therefore, fieldwork and 'routine reflexivity' are vital aspects of anthropological studies, highlighting development shortcomings and illuminating, challenging, and extending anthropological thinking (Strathern, 1987 in Venkatesan and Yarrow, 2012 p6).

Selected Method: Analytical Autoethnography

The classic research method of social anthropology is ethnography, a method for qualitative research where the researcher observes activities, interacting and analysing information in a community or organization to interpret meanings, functions and consequences of actions and institutional practices (Hammersley and Atkinson, 2019). The bulk of ethnographic research of the international development world focuses on observations of international institutions, their policy production, and practices (Mosse, 2005). Treating international development as a community allows analysis of the social processes, such as how development actors exercise agency and how they respond and relate to one

another, including power relations (Crewe and Axelby, 2013). Autoethnographic studies include researchers as both observers and active participants in these studies (Hammersley and Atkinson, 2019 pp210-211), with their fieldwork highlighting development practice shortcomings and challenging and extending anthropological thinking (Venkatesan and Yarrow, 2012). Autoethnography is well established as a research method within the broader field of anthropology of development. The most prominent examples are the studies in Mosse's *Adventures in Aidland* (2013), many of which have informed my approach within this thesis (Eyben, 2013; Green, 2013). These analyses by development practitioners within their own professional context generate observations and questions about how development practice is actioned, implemented, and sustained.

However, such analyses must go beyond critique. To this end, the ***analytical autoethnography*** method (Anderson, 2006) explicitly links empirical accounts of the world and its relationships to theories about how this world might change for the better (Delamont, 2007; Gow, 2002; Hammersley and Atkinson, 2019). Using analytical autoethnography, development researchers reflect on their unique role and influence within the research process (Hammersley and Atkinson, 2019). For example, Mosse (2013 p83) identifies his fieldwork as being conducted in offices, corridors, coffee shops, canteens, the meetings, and seminars of the World Bank headquarters, linked to broader policymaking processes. In addition, analytical autoethnographic methods encourage researchers to link their empirical experience with theoretical analysis (Anderson 2006). For example, Green (2013) describes her work both empirically (focused on the purposeful manipulation of text) and theoretically (centred on knowledge development processes that nurtured and maintained social relationships within and outside her agency). Moore reflects both on the practice and broader theory related to his work:

> *As I gained more knowledge about effective development practices and the importance of local solutions for local problems, I began to realize that many international development workers arrived with preplanned solutions to community issues or problems, without actively engaging in discussions with the community.… I began to question the effectiveness and efficiency of the development organization I worked for, and international development in general, and began to explore various international development theories* (Moore, 2014 pp5-6).

Analytical autoethnography has been used in global health analysis, although not widely. For example, Harper (2013) identifies how examining the local politics of health knowledge production (empirical) reveals how geopolitical and economic relations framed as 'development' embed inequality and unequal power relations (theoretical). Fassin drew on his own professional experience to study how formal and informal encounters with development partners presented opportunities to develop a more complex relevant vision of the HIV/AIDS epidemic in South Africa (2013). That the method has not been

taken up more widely reflects a broader epistemological challenge in health as a development field, which is dominated by medical and scientific epistemologies and knowledge processes.

The method for this thesis integrates the five critical features of analytic autoethnography: complete member researcher status, analytic reflexivity, narrative visibility of the researcher's self, dialogue with informants beyond the self (Anderson, 2006). In all parts of the analysis, I am identified as a member with researcher status. Then, taking a reflexive approach, I examine my role and that of my colleagues and interlocutors, with these relationships and insights made visible through the documents under examination.

Finally, analytical autoethnography commits to theoretical analysis (Anderson, 2006). This thesis links empirical analysis of my published work to anthropological theories about social processes, knowledge, and power. It first analyses my published content and its role in knowledge development and then examines my published work in terms of social processes and partnerships. It then analyses the published work within the theoretical framing of Michel Foucault focused on the relationship between knowledge and power, in a closing chapter that explores more deeply the ensemble of institutions and power strategies across my experiences (Gaventa, 2006). Here, I draw on Gaventa's multidimensional framework for analysing power in international development with a specific focus on how knowledge interacted with ***forms*** of power (visible, hidden, and invisible), **spaces** of power (closed, invited, or claimed), and **levels** of power (global, national, local) (Gaventa, 2006; Gaventa, 2019).

This methodological approach delivers the call for anthropology 'beyond critique' (Venkatesan and Yarrow, 2012), linking empirical and theoretical perspectives into an integrated account of the development world (Delamont, 2007; Hammersley and Atkinson, 2019). Noted in the literature review, CRVS is linked to Foucault's theories of biopower. However, whilst biopower itself is an interesting theoretical framing, I cannot link my publications directly to a broader understanding of the use of biopower by nation-states. Therefore, the analysis does not use this theoretical framing for its primary exploration, although I include a vignette on the use of CRVS for policies focused on Indigenous Australians in Chapter 3. Instead, the thesis focuses on my experiences as they can be related to Foucault's theories about the dynamic and reciprocal relationship between power and knowledge.

Challenges

Autoethnography as a research method is not without critique (Holman Jones, Adams, and Ellis, 2013 p32). To some, it is insufficiently rigorous and raises questions about external reliability, validity, and generalisability (Ellis *et al*., 2011). For example, Mosse encountered significant objections to his use of autoethnography to document the social processes of development success and failure, with his former colleagues viewing the approach as disrespectful, inaccurate, and professionally damaging (2013, p21). However, Pigg reflects that autoethnography is appropriate for global health, enabling an ethnographer

to step to the side of the global health 'juggernaut' by analysing 'global health' as a social field of activity. This allows examination of activities and relationships, contradictions, contests, ethical dilemmas, and political consequences (2013 p133).

A challenge for this thesis arises with epistemology. The technical underpinnings of my published work are health sciences and statistics, which assume levels of scientific evidence and rationality (Piot, cited in McInnes et al., 2020). This scientific focus may conflict with the anthropological perspective, which emphasises social and often power-oriented aspects of development practice (Hammersley and Atkinson, 2019). However, anthropological studies have tackled a wide range of international development subject matter, including economic, scientific, cultural, and social analyses (Mosse, 2013). As noted earlier, anthropology and health are not inconsistent, with anthropological studies contributing to health responses during epidemics. From this perspective, health and anthropology can be seen as complementary rather than in conflict.

A further challenge relates to observations on the actions of others. This thesis presents *my* perspective on the progress and experience of my published work. However, as anthropology recognises, others who experienced these 'social processes' with me may have differing viewpoints, including concerns about accuracy, respect, and damage to professional reputations (Mosse, 2013 p21). This is particularly true for health as a development agenda, where 'stepping outside of the analysis of content to reflect on form or relationships can invoke anger and resentment from insiders' (Harper, 2013 p124). Colleagues and partnerships have been a critical aspect of my experience, and during the writing process, I drew on observations and comments from others, which provided me with insights and helped shape and define my work. Where I reference opinions or comments by colleagues in the field, I have de-identified these comments.

Document Typology

Documents such as policies, plans, and strategies are critical to global health policies, with documents incorporating policy ideas becoming part of the cognitive architecture (Schiffman and Smith, 2007). From an anthropological perspective, documents can be used to understand development knowledge and power, including how knowledge permits and secures power and how power forms knowledge (Faubion, 2000; Paras, 2020); with documents developed from fieldwork highlighting shortcomings and extending development thinking (Venkatesan and Yarrow, 2012).

Therefore, it is crucial to understand the types of documents in my body of work as a backdrop for this thesis. The Annex to this thesis includes each of my authored documents and a synopsis for each. There are two main types of development documents in my body of work. Firstly, a broad range of development ideas and documents in global health are embedded in scholarly work (Smith and

Schiffman, 2020), including **academic literature** which uses peer review processes. For example, in my published work for CRVS, two such journal articles (Boerma *et al*., 2016 in Annex A.8; Jackson *et al*., 2018 in Annex A.10) were published after using formal peer review processes.

Secondly, as Green notes, a wide range of **development literature** is produced by think tanks, universities, development institutes and development agencies (2013 p37). My body of work includes a wide range of this type of development literature, for example, publications based on fieldwork (Schmider, 2010 in Annex A.1; University of Queensland, 2012a, 2012b and 2012c in Annex A.2), or updating general development knowledge and progress (Canada IDRC, 2018 in Annex A.9). These documents were produced using formal, reviewed university publication processes; however, they were designed with a non-academic audience in mind. For example, the purpose of my first document in this body of work (Schmider, 2010 in Annex A.1) was to fill a gap in the development literature for CRVS practitioners in developing countries, capturing research findings and knowledge generated by the University's activities. Finally, my published work includes formal international organisation publications (WHO, 2013 in Annex A.5; WHO, UNECA and ASSD, 2015 in Annex A.7; World Bank and WHO, 2014 in Annex A.6). These documents build on fieldwork experiences to inform broader policy-setting in international development, especially for the WHO, which issues normative standards, guidelines, and technical documents (WHO, 2020).

Structure of the Thesis

Research Question and Approach

This critical analysis draws on both development and academic anthropological perspectives, first exploring my published work from an empirical perspective.

- **Research Questions include**: How did the partnerships that I collaborated in contribute to the shift in the global CRVS agenda? How did the knowledge that my colleagues and I developed contribute to the shift in the global CRVS agenda?

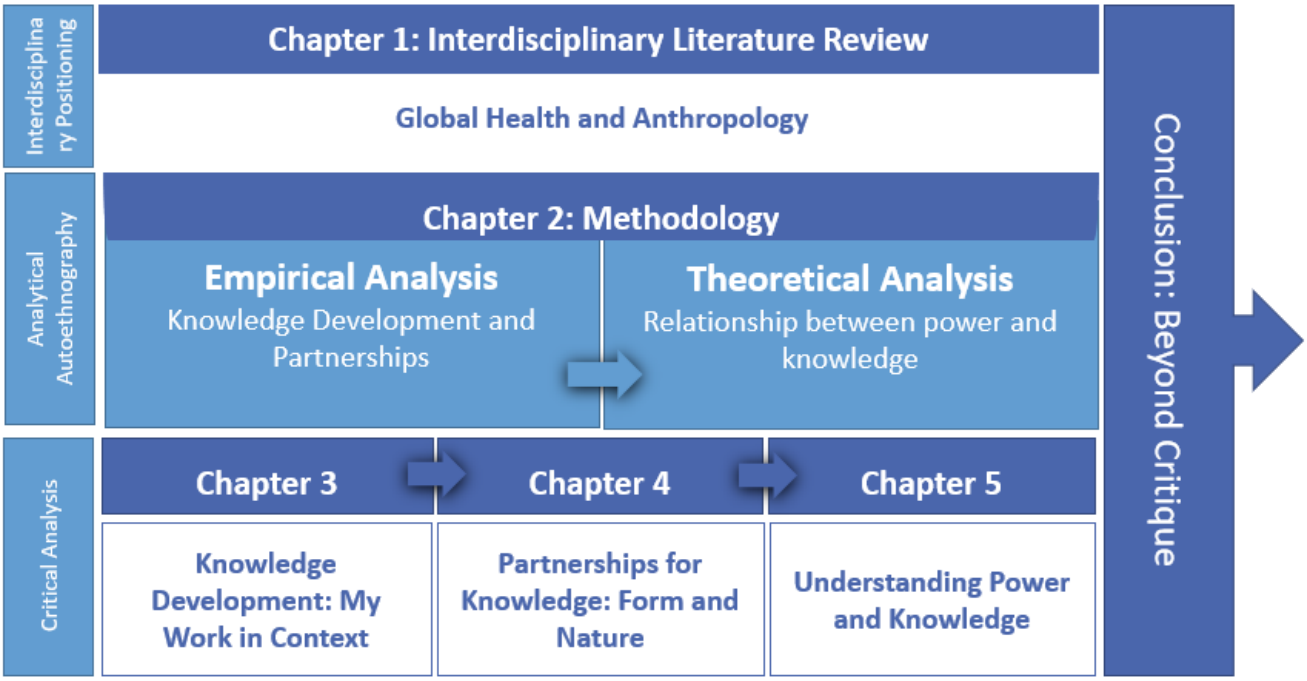
Seeking to go 'beyond critique', the research questions for the consequent analysis in Chapter 5 link the empirical to the theoretical, refocusing the experiences across my body of work through the lens of Foucault's theories about the reciprocal and dynamic relationship between knowledge and power.

- **Research Questions include**: How do development actors use knowledge and power to shape international practice in the field of CRVS?

The selected methodology and approach links empirical and theoretical perspectives. Three sequenced analyses are designed to take the empirical analysis of my work to a theoretical framing focused on the relationship between power and knowledge (Figure 2 below).

- This research first explores my published work from an empirical perspective, with Chapter 3 examining my body of published work in phases of knowledge development for CRVS.
- The thesis then explores the social processes of development surrounding my published work, with Chapter 4 examining the form and nature of partnerships and their impact on knowledge processes and practice.
- Finally, Chapter 5 draws on Foucault's theoretical conceptions to focus attention on the relationship between power and knowledge across my published work, including analysing the relationship from the perspective of reciprocity and dynamism, where knowledge permits and secures the exercise of power and the exercise of power forms knowledge (Faubion, 2000; Paras, 2020).

Figure 2: Beyond Critique: Linking Empirical and Theoretical Perspectives



3. Knowledge Development: My Work in Context

This Chapter explores my published work from an empirical perspective, examining my body of published work in phases of knowledge development for CRVS. This chapter starts with my understanding of CRVS from an anthropological perspective, developed from my work using CRVS to inform government policies for Indigenous Australians. It then analyses my body of international work, examining the phases of knowledge development across my publications and exploring how ideas and knowledge contributed to revitalising this neglected international development agenda. This body of work built on my in Australia, where I led CRVS activities that informed national and subnational policy agendas (Table 3 below).

Table 3: Publications Grouped by Stages of Knowledge Development

Knowledge for Neglected Agendas	Policy Windows	Innovation
Schmider, A. (2010). Advocating for civil registration: guide to developing a business case for civil registration. University of Queensland, Australia University of Queensland (2012a). Country Report: Mongolia Civil registration and vital statistics assessment and health information systems training. University of Queensland, Australia University of Queensland (2012b). Country Report: Philippines CRVS improvement and strategic planning. University of Queensland, Australia University of Queensland. (2012c). Country Report: Cambodia CRVS improvement and strategic planning. August 2012. University of Queensland, Australia World Health Organization (2012). Civil Registration and Vital Statistics Resource Kit. WHO Geneva World Health Organization (2013). Translating Recommendations into Action: Report on Progress Towards Implementing the CoIA Recommendations. WHO Geneva World Health Organization (2014) Implementing the Commission on Information and Accountability Recommendations: 2014 Progress Report. WHO Geneva World Health Organization (2015) Implementing the Commission on Information and Accountability Recommendations: 2015 Progress Report. WHO Geneva	World Bank-World Health Organization (2014). Global Scaling Up CRVS Plan 2015-2030. World Bank, Washington. WHO, UNECA & ASSD (2015). Improving Mortality Statistics in Africa: Technical Strategy 2015 – 2020. UNECA Ethiopia.	World Health Organization (2013a). Strengthening Systems through Innovative Approaches in the Health Sector: Guiding Principles. WHO Geneva Boerma, T., Harrison, J., Jakob, R., Mathers, C., Schmider, A., Weber, S. (2016). 'Revising the ICD: Explaining the WHO approach'. The Lancet Vol 388 issue 10059 Canada International Development and Research Centre. (2018). Global State of CRVS. IDRC, Canada. Jackson, D., Wenz, K., Muniz, M., Abouzahr, C., Schmider, A., Braschi, M., Kassam, N., Diaz, T., Mwamba, R., Setel, P., Mills, S. (2018). 'Civil registration and vital statistics in health systems'. Bulletin of the World Health Organization 2018:96
Australian CRVS System		

CRVS and Indigenous Australians

My understanding of CRVS and its prominent and unique role in government policy processes started when I began working with CRVS analysis to influence government policies towards Indigenous people in Australia. In 2006, I was invited to lead a new unit in the Queensland Government dedicated to improving independent data and statistics about Indigenous people. My boss described it as one of the most challenging and important areas to improve government data.

Indigenous people in Australia are disadvantaged in every way – from birth to death, across economic, social and health measures (Queensland Government, 2008). There is an anthropological and sociological dimension to understanding the breadth and depth of Indigenous people's ongoing disadvantage in Australia. Indigenous people in Australia have suffered deep and abiding discrimination and inequalities under colonial and subsequent government rules. From colonisation in the eighteenth and nineteenth centuries and continuing through the twentieth century, governments had used coercive policies and structural violence (Billaud and Cowan, 2020) towards Australia's first people. Consistent with Foucault's conception of disciplinary power (Lynch, 2011), governments over this period had established direct control over how Indigenous people lived. For example, any person could be removed or moved at any time, at the government's directive, in a policy known as 'protection':

> *It shall be lawful for the Minister to cause every aboriginal within any District … to be removed, and kept within the limits of, any reserve situated within such District, in such manner, and subject to such conditions, as may be prescribed. The Minister may, subject to the said conditions, cause any aboriginal to be removed from one reserve to another.* (Public Acts of the Parliament of Queensland, 1897 p6175)

CRVS systems were crucial to how governments exercised this discipline. Between 1939 and 1965, Aboriginal people were required by law to seek permission from the 'protector' to get married (Antidiscrimination Commission of Queensland, 2017). Consecutive Queensland Governments in the twentieth century attempted to force acculturation of Indigenous people into non-Indigenous societies through the systematic removal of Indigenous children from their communities. This policy displaced and fractured indigenous families across generations (Pollock *et al*., 2018). As a result, Indigenous births were not registered in Queensland consistently (Queensland Government, 2021). This was partly because of poor administrative records. However, not registering births was an attempt by Indigenous people to protect their children from removal policies (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2021).

CRVS also tells a story of the shifting power of the state on Indigenous people's lives from a disciplinary focus to one of making live and letting die (Taylor, 2011). By 2006, the disciplinary focus of the state shifted to a focus on improving the health and wellbeing of Indigenous people. As a result, data from life events such as births and deaths became essential to quantifying and creating health, social and economic policies to address disadvantages. However, historical mistrust of government and its disciplinary actions created an ongoing distrust of authority. This mistrust impacted Indigenous people's trust in government, negatively affecting the registration of births, deaths, and marriages. Consequently, it was challenging to understand the health, economic, and social disadvantages they faced (Griffiths et al., 2019; Queensland Ombudsman, 2018). The continuing discrepancies in

registration of Indigenous people's births made many Indigenous people effectively invisible to the state (Queensland Ombudsman, 2018 p4) and perpetuated disadvantages. For example, individuals who did not have their births registered faced lifelong challenges in school enrolment, obtaining a driver's licence, accessing government benefits, and opening a bank account (Queensland Ombudsman, 2018).

Against this backdrop of continuing disadvantage, it was with both professional and personal hesitation that I took this role. The new role focused on quantifying and classifying Indigenous life (Hanna *et al*., 2013), consistent with Foucault's notion about biopower and the optimisation of life (Foucault, in Bertani and Fontana, 1997). However, I had married into an Aboriginal family and had a husband and children with Aboriginal heritage. I also recognized (as well as a white immigrant Australian could) the personal and population inequalities and disadvantages experienced by Aboriginal people. I was concerned about being placed in a challenging position between my family and the state. However, as my boss pointed out, the role was to provide the 'facts' which told the story of the continuing inequality and challenge Indigenous people faced in Australia to improve the situation.

The data we produced were shocking for a high-income country. Indigenous people experienced significant differences in life expectancy, health, and mortality (Queensland Government, 2008; Queensland Government, 2009). Our work showed that Indigenous Queenslanders died almost 20 years earlier than non-Indigenous Australians (Queensland Government, 2008). Indigenous children were twice as likely to die compared to non-Indigenous children (Queensland Government, 2009). Many Indigenous children were utterly invisible, dying without even having their births registered (Queensland Ombudsman, 2018).

Later, as Director at the Australian Bureau of Statistics, I published national statistics for Indigenous Australians using CRVS data for national health, social and economic policymaking, which again confirmed the significant disadvantages of Indigenous Australians (ABS Cat 3303.0, 2010; 2011; 2012). Most confronting of these statistics were the Indigenous suicide deaths rates. Suicide rates in Australia are twice as high for Indigenous people than for non-indigenous people (ABS, 2010), with suicide deaths amongst young Indigenous men amongst the highest in the world (The Commonwealth Youth Programme, 2016 p28). As statisticians, we tried to approach these issues at a dispassionate, technical level. However, in doing so, I was conscious that we should not perpetuate the process of dehumanisation (Rees, 2014 p461). The dehumanisation of Indigenous people in published statistics and policy came in many forms. For example, (non-Indigenous) statisticians often engaged in substantial, heated debates about how 'Indigenous' status should be ascribed. One view (my own) was that people had the right to identify themselves as being of Indigenous heritage. However, from my work with various data collection processes, I knew that Indigenous people could be treated differently within government systems (police, justice) where they were identified as Indigenous. Therefore, in my

view, Indigenous people also had the right *not* to identify themselves as Indigenous where their wellbeing was placed at risk.

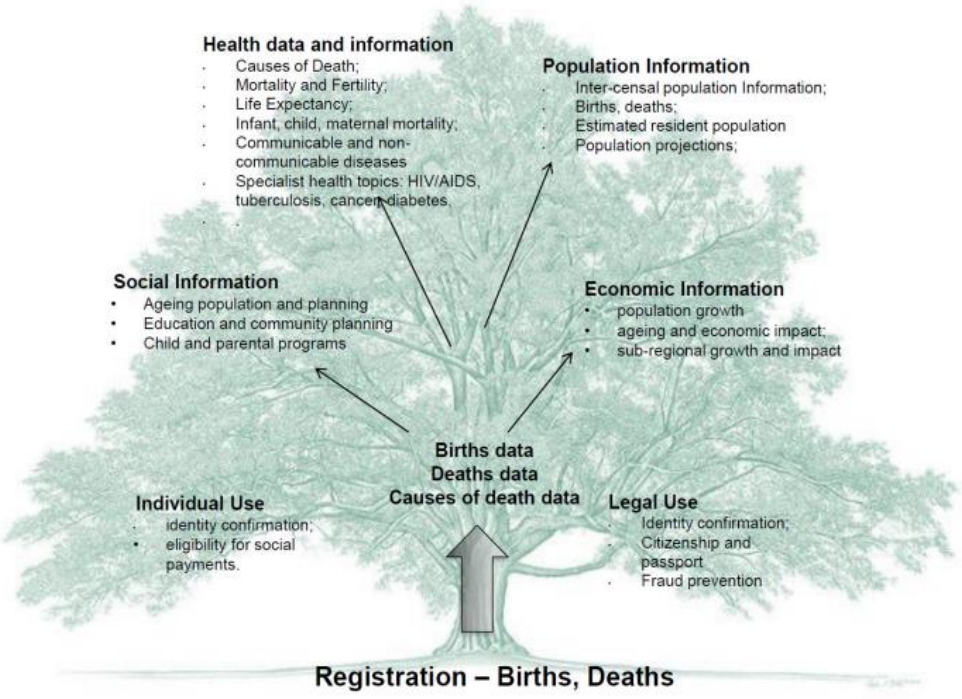
The opposing statistical view was that an individual's right to identify should not get in the way of a robust set of statistics. Some statisticians proposed linking data together to ensure that indigenous status was automatically ascribed across other data. This meant that, for example, if people were identified as having Indigenous heritage on their birth certificate, they were 'ever-Indigenous' and had no further choice about how they preferred to be identified. In effect, ongoing indigenous status was ascribed by the state. As one of my colleagues argued, people were only one pen stroke away from perpetual discrimination in this scenario. This example of statistical methodological arguments shows that there are often ethical and moral dimensions to these dry statistical debates. That these discussions took place without the inclusion of the people affected did not seem to bother anyone. These debates were finally resolved in 2012, when it was agreed, in consultation with Indigenous representatives, that the Indigenous status of individuals be should not be ascribed or altered on source data sets. Instead, self-reporting was agreed as the most accurate (and ethical) means of ascertaining a client's Indigenous status (Australian Bureau of Statistics- AIHW, 2012).

My work at the government level gave me an appreciation for how CRVS data can expose and address societies' most complex and unpredictable problems (Head and Alford, 2013). However, it also showed that CRVS systems are not neutral; they are alive with culture, history, and practice. Thus, with a deep understanding of the policy and technical importance of CRVS, I moved to the World Health Organization to take the reins of CRVS as an international development concern.

Knowledge for a Neglected Global Agenda

The knowledge development process started with CRVS as a neglected agenda. My work in Australia emphasised the importance of CRVS to people and governments. However, at the outset of my international work in 2010, it was clear that this importance was not universally recognised. Many countries could not record or count births and deaths (Abouzahr *et al*., 2007; Mahapatra *et al*., 2007). As a result, advocacy was needed to make the case to improve CRVS. Therefore, the earliest contribution of my published work focused on making a business case to governments about the importance of CRVS to government policymaking (Schmider, 2010 in Annex A.1). This publication set out a comprehensive analysis of the costs and benefits of CRVS improvement. I also sought to make the connection between CRVS and a wide range of different government activities. I developed a diagram – the 'CRVS tree' – to show the overall value and impact of CRVS data for policy information, based on my experiences in Australia (Figure 3 below).

Figure 3: The CRVS Tree

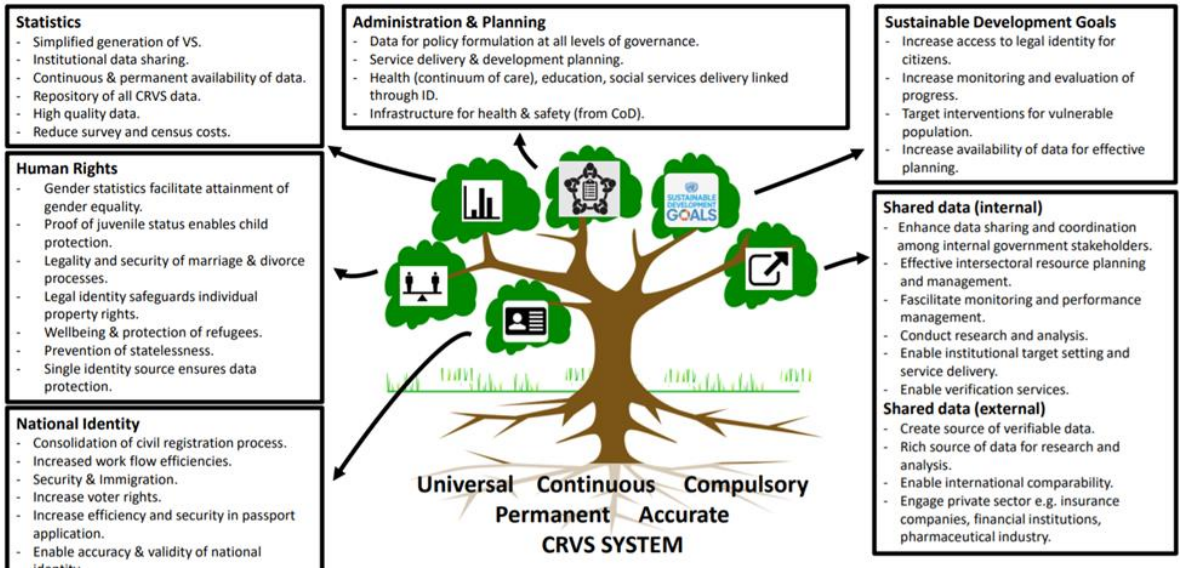


Source: *Schmider, 2010 In Annex A.1 p4*

The tree showed firstly how CRVS data was used by individuals for legal purposes, for example, birth documents used for citizenship and passports. Although I was unaware of Foucault's arguments about biopower at the time, as I developed the diagram, I was surprised by how CRVS information was used across so many areas of government policy. The diagram shows how data are aggregated for use across multiple policy-making domains, for example, social and health programmes and planning and economic projections. In countries like Australia, which have a functioning CRVS system, governments distribute money according to population growth (measured by births and deaths) and seek to improve their population potential through social and health policy and programmes (Ingram, 2020). The conceptualisation of CRVS as a tree resonated with colleagues in other countries and my diagram was later adapted in Ghana (Figure 4), Samoa, Sri Lanka, and Ethiopia to show how CRVS was a 'living infrastructure'.

However, an early lesson for me was that this initial business case only referenced high-income country examples in the UK and Australia. This point emerged during fieldwork and international meetings in Asia and the Pacific, which revealed that the assumptions I had included – for example, that countries used western-oriented budgeting processes and cost-benefit analyses – did not hold for all countries. As a result, I later modified the approach to focus on advocacy processes rather than budget processes, an approach relevant to a broader range of country settings (WHO, 2012 in Annex A.3).

Figure 4: Ghana's CRVS Tree

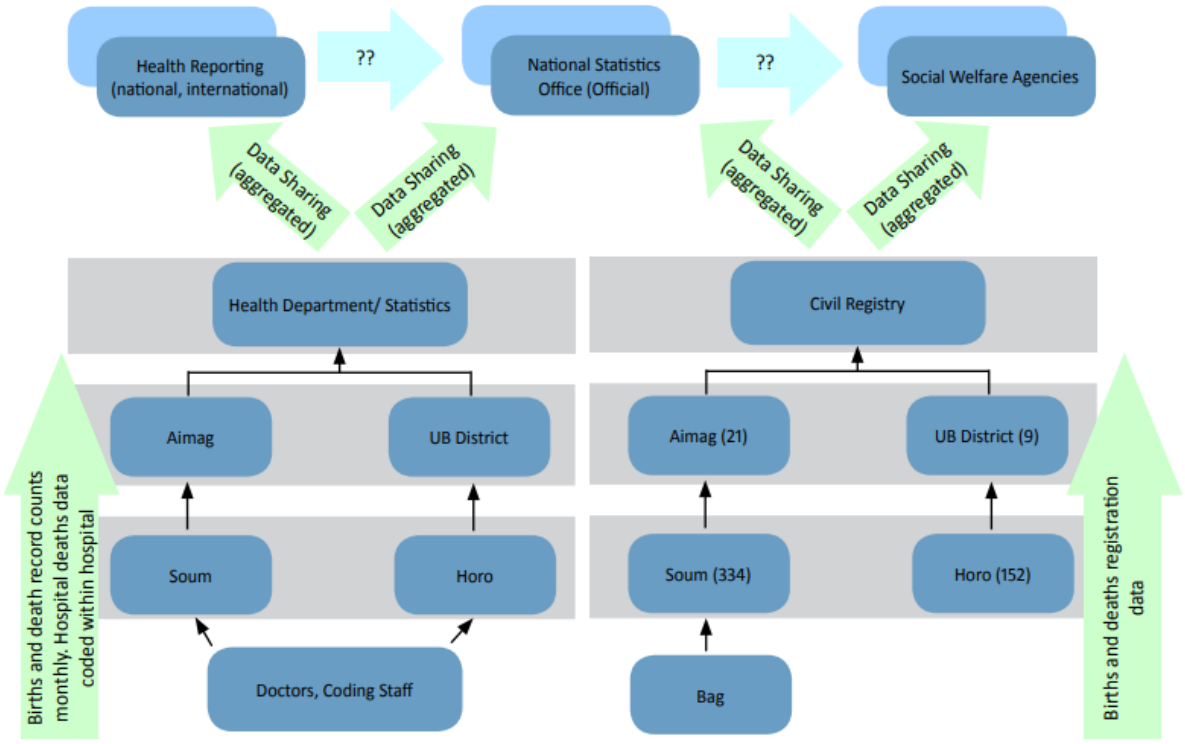


Source: *Government of Ghana, 2017*

My work on CRVS continued with field visits to many countries to support their campaigns and programmes to improve CRVS. As Eyben (2013) notes, fieldwork is an essential aspect of development practice that creates a greater understanding of the lives of poor people and their communities and helping development professionals to link micro-reality to macro-level policy and action. This was true in my experience. As I visited different countries, I observed a great deal about the role that CRVS played in differing contexts. I co-authored university research publications that documented CRVS systems in Mongolia, the Philippines and Cambodia from these field visits, following a formal, comprehensive methodology (WHO, 2012 in Annex A.3).

These documents produced first-hand knowledge about how CRVS systems were functioning in countries. For example, I mapped the data flows through national CRVS systems, providing insights into how laws and governance processes surrounding CRVS systems. For example, I mapped and published CRVS data flows in Mongolia for national stakeholders (Figure 5) (University of Queensland, 2012a, in Annex A.2). This analysis revealed the challenges of coordinating multiple CRVS agencies, a challenge replicated in most other countries I visited.

Figure 5: Mongolia: CRVS Data Flow Analysis



Source: *University of Queensland, 2012a in Annex A.2 p17*

These publications also recorded details about CRVS development project failures. For example, an international NGO ran a pilot CRVS project in Cambodia, a project later abandoned due to a lack of donor finance. However, the registration initiative had not focused on the quality assurance of data into the system. Therefore, legal identity records for many people contained permanent errors (Cambodia Report, University of Queensland, 2012c in Annex A.2 p13). The result was that people could not source replacement registration certificates because their details could not be verified, perpetuating the problem.

In Mongolia, weaknesses in implementing the complex International Classification of Disease (ICD) affected the quality of national health data (University of Queensland, 2012a in Annex A.2 p15). The ICD is one of the two global CRVS standards and has been part of the WHO mandate since its inception in 1948. ICD provides a crucial analytical base in many countries, delivering population health data about causes of death. It is fundamental to research and health system monitoring, as shown in the 'CRVS tree' (Figure 3, previous). It has also been adapted over time (Boerma *et al*., 2016 in Annex A.8), primarily driven by the needs of high-income countries (Roberts *et al*., 2015). However, as shown in my later work, implementation was weak in many countries. For example, recording disease and deaths using ICD in Mongolia was central to understanding public health needs relating to alcohol use and the

prevalence of hepatitis (University of Queensland, 2012a in Annex A.2 p7). Understanding these micro-realities from fieldwork became critical to influencing macro-level policy and action (Eyben, 2013).

Moving to WHO in 2013, my early global work focused on collating evidence of country-level commitments to improving CRVS systems and identifying the demand for better service from global agencies. I translated the qualitative approaches I had observed during fieldwork in developing countries into a quantitative count used for global policy development. As shown in Table 4 (below), I counted the political commitments published in formal resolutions by Ministers in the regions, as well as countries that had formally analysed their CRVS systems, some of which I had documented (University of Queensland, 2012a; 2012b; 2012c in Annex A.2). The tallying of individual country commitments and actions delivered a powerful message to the global community that countries were seeking change.

Table 4: Global CRVS Scaling Up Plan - Status of CRVS (Excerpt)

Country	COIA country	CRVS Rapid Assessment	CRVS Comprehensive Assessment	CRVS Strategic Plan / Committee	CRVS Political Commitment
Afghanistan	Yes	Yes	Completed	National CRVS Plan	CRVS Regional Strategy endorsed by Eastern Mediterranean Regional Committee – Health Minister
Angola	Yes		Planning assessment		Civil Registration Minister – Health Ministers in 2014
Azerbaijan	Yes	Yes			
Bangladesh	Yes	Yes	Completed	National CRVS Plan and Costed investment Plan	Likely in 2014 through UNESCAP process
Benin	Yes				Civil Registration Minister – Health Ministers in 2014
Bolivia	Yes			Country works within PAHO Regional Committee framework since 2008	Health Ministers through PAHO Regional Committee
Botswana	Yes		First completed and new one underway	National CRVS Plan	Civil Registration Minister – Health Ministers in 2014

***Source**: World Bank and WHO 2014 Annex 6 pp 55-58*

I analysed and collated the qualitative data from field visit reports to publish three global CRVS progress reports focused on seventy-five developing countries (WHO, 2013, 2014, 2015 in Annex A.5). Gathering this information as evidence of progress across countries proved crucial in influencing global actions. For example, in 2013, only eight countries had completed a comprehensive CRVS review (WHO, 2013 in Annex A.5 p14). In this same document, I also revealed the lack of global action to support the CRVS agenda, despite the significant country and regional commitments (*ibid* p16). However, by 2014, country commitment and progress had grown significantly, with fifty-one countries having completed a review of their CRVS systems (WHO, 2014 in Annex A.5 p2). By 2015, 64 countries had completed a review of their CRVS systems (WHO, 2015 p18 in Annex A.5). This analysis proved critical during policy

windows in 2014 and 2015, informing global and regional strategy development at the end of the MDGs and during the Ebola outbreak in West Africa in 2014, as explored in the following section.

Policy Windows

As shown in the previous section, documenting the perspectives and actions of stakeholders in developing countries was critical to understanding the demand for better technical support for CRVS. However, this work also became important during a 'policy window' in 2014 (Smith and Schiffman, 2007), when it became clear that MDG targets for women and children would not be met (United Nations, 2015). CRVS systems were vital to monitoring maternal and child deaths, and therefore were essential to the MDG targets to reduce these deaths (WHO, 2013 in Annex A.5). However, many developing countries lacked reliable data about births or deaths of women and children. This lack of data affected development practice, preventing governments and international agencies from understanding the scale of the problem and developing policies to improve health outcomes. Therefore, CRVS attracted new attention, highlighting the extent of the failure of international policy towards women and children. To address the gap in international development policy towards CRVS, in early 2014, I contributed to a new Global CRVS Scaling Up Plan with the World Bank and Canadian Government (World Bank and WHO, 2014 in Annex A.6). This Plan drew extensively on the technical fieldwork of my previous work documenting the state of CRVS. Annexes in this Plan included the tables I had used to monitor CRVS progress across 75 countries (World Bank and WHO, 2014 in Annex A.6). In addition, we created global maps visualising worldwide implementation weaknesses (*ibid*, Annex2); and established the first global targets to implement better CRVS (World Bank and WHO, 2014 pxiv in Annex A.6).

However, I was also conscious from my experience publishing CRVS data in Australia and my first international publication (Schmider, 2010 in Annex A.1) that there were dangers in making assumptions about people and practices without direct consultation. Therefore, with my World Bank colleague, I ensured countries were both consulted and represented within the global process for this plan, including them in the publication development (recognised in the Acknowledgments) and publishing case studies about their experiences (Annexes 3 and 6) (World Bank and WHO, 2014). Our work attracted the investment of $US100 million in the CRVS agenda by the Government of Canada in a new Global Financing Facility at the World Bank (Canada IDRC, 2018 in Annex A.9). Both the Plan and the financing were uncharted policy territory for CRVS and created new social processes examined more deeply in Chapters 3 and 4 of this dissertation.

A second CRVS policy window resulted from the Ebola outbreak in West Africa in 2014-2015. At that time, the World Bank and WHO had just published maps that showed the extent of the failure to implement CRVS in many countries (Figure 6, below). Therefore, we knew that most countries could

not quantify life and death using CRVS data. During the Ebola outbreak, the failure to record deaths in real-time through CRVS systems meant that public health policy and responses were severely impacted (UNECA, 2015). The Ebola outbreak was a devastating example of policy failure for the WHO (Harman, 2014). As Rees (2014) noted, it represented a moment where disease threatened humanity; however, the global health institution could not respond. This was partly because there was insufficient data to understand the extent of the outbreak and the number of deaths (UNECA, 2015).

Figure 6: Quality of Cause-of-Death Statistics, 2012

Source: *World Bank and WHO, 2014, p.35 in Annex A.6*

In early 2015, the African CRVS Ministers published a resolution, calling for WHO, in collaboration with African partners, to develop improved methods for using the ICD in the African context (WHO, UNECA and ASSD, 2015 piv in Annex A.7). History is relevant to understanding *why* African Ministers demanded better service from the WHO. The ICD was a core component of CRVS systems and was the first international standard that WHO is mandated to produce. However, it was maintained by an academic community whose elite academic arguments about the ICD and its implementation had resulted in professional divisions over many decades. My first few international meetings at WHO headquarters comprised sitting in days-long meetings debating with academics on the finer (theoretical) points about the ICD. While the technical discourse seemed dry and objective, academic stakeholders were, in fact, vying competitively for the global prestige that would come from having their preferred approach formally endorsed by the WHO. As a result, we spent significant amounts of international meeting time deciding which approach was better. The Ebola outbreak showed the catastrophic result of these

academic arguments. None of the various tools could be mobilised for rapid data collection during a real-world health emergency. The consequence was that deaths data were not well collected in most countries, as I had observed in my fieldwork. Even worse, WHO and the academics offered no solution about how the situation could be improved. As a result, the ICD was removed from the reality of most countries in Africa.

In response to this resolution, I authored the document *Improving Mortality Statistics in Africa: Technical Strategy 2015 – 2020* with African partners, known as the 'post-Ebola technical strategy' (WHO UNECA and ASSD, 2015 in Annex A.7). My African partners and I used the devastating experience of the Ebola outbreak as a policy window to focus attention on the changes needed for African countries to improve their CRVS data. We wrote the technical strategy to reconcile this chaotic, elite academic community that had dominated the ICD discourse for decades. We included a section on 'evolution' that sought to present these disparate technical voices as components of an evolving CRVS system (WHO UNECA ASSD, 2015 in Annex A.7 pp3-5). We also included a section devoted to ideas for modern methodology, designed to appeal to African policymakers and the disparate academic community (*ibid*, pp8). Importantly, we incorporated the experiences of African counterparts into the strategy, drawing in knowledge from CRVS reviews they had undertaken of their systems. Because it was written *by African countries, for African countries*, more than fifty African countries approved this strategy at the 11th African Symposium on Statistical Development in Namibia in November 2015 (APAI-CRVS, 2015).

New Ideas

As shown in the previous section, global health policy windows, and the business cases that result from them, are often defined by heightened concerns about death and disease. However, these policy windows also represented opportunities to create new relationships between knowledge and power (Billaud and Cowan, 2020). Moreover, as my published work shows, these were also periods representing innovation and experimentation in thought (Ingram, 2020). Published documents from field trips with country CRVS practitioners (WHO, 2012a; 2012b and 2012c) established new or improved actions and improvements countries could take. These ideas most often came from country practitioners themselves. Practitioners in-country seemed, for the most part, very focused on how to improve their CRVS systems. Therefore, I found it easy to engage about CRVS innovation by discussing how they had sought to develop new or improved processes (WHO, 2013a in Annex A.4). Articulating these various experiences within the united framework of 'innovation' as a development policy dialogue proved influential in establishing development partnerships for this neglected agenda and in changing global policy, discussed later in this analysis. My publications began to articulate these local innovations, for example, identifying how innovations could be introduced through the health sector (WHO, 2013a p10 in Annex A.4).

I also used the narrative about innovation to address weaknesses within the WHO's CRVS processes related to the ICD. ICD had been adapted over time (Boerma *et al*., 2016 in Annex A.8), although this had been driven primarily by the needs of high-income countries (Roberts *et al*., 2015). Thus, ICD had evident value to high-income countries. The WHO assumed that developing countries would follow the lead of high-income countries. However, the CRVS maps in our report (World Bank and WHO, 2014 in Annex A.6) showed that the implementation and use of the ICD in these countries was generally weak.

Nevertheless, there were signs of innovative activity stemming from the developing countries themselves. My fieldwork showed that many developing countries saw ICD as necessary for their health systems (University of Queensland, 2012a; 2012b; 2012c in Annex A.2), and field experience with data scientists in Africa and Asia revealed that many countries adapted ICD within their context (Boerma *et al*., 2016 in Annex A.8 p2476). Using formal documents as the vehicle, I built on these observations, publishing 'innovation' as a theme within the *Global CRVS Scaling Up Plan*, dedicating an entire chapter to 'The Opportunity to Transform CRVS' (World Bank and WHO, 2014 pp13-18 in Annex A.6). In the post-Ebola technical strategy, I dedicated a section to designing better systems (WHO, UNECA and ASSD, 2015 pp7-9 in Annex A.7). In addition, new ideas about adapting global approaches were published in journal articles and documents from respected agencies (Canada IDRC, 2018 in Annex A.9; Jackson *et al*., 2018 in Annex A.10).

Unashamedly, publishing about innovation was an attempt on my part to influence a stagnant global discourse. Writing about CRVS as 'innovation' in journals and formal development documents was a deliberate action to influence the CRVS agenda at two levels. Firstly, development agencies often consider local experience irrelevant because it is messy and complex (Eyben, 2013). Therefore, journal articles and well-crafted development documents enabled local concepts to be presented in a formal and orderly way. Secondly, publishing in journals and formal development documents was a strategy to improve the global discourse about CRVS. For many global colleagues, journals and formal development documents were a respected intellectual mechanism where ideas are incorporated and accepted as cognitive architecture (Schiffman and Smith, 2007).

Summary

My published work is best understood as part of a development 'ideas' journey that generated new knowledge and took advantage of policy windows to address a long-neglected international agenda. Documents were central to this journey, with each published work building on the ideas and narrative of previous work, secured in the foundations of country experiences and practical knowledge. These documents and the social processes that led to their publication provide a crucial foundation for examining the partnerships and power in the following sections.

4. Partnerships: Form and Nature

The second research question for this thesis is: How did the partnerships I collaborated with contribute to the global CRVS agenda? Partnerships were essential to knowledge development across my body of work, especially during the transition to the SDGs and the policy windows which emerged at this time. However, the term 'partnership' is one of the most under-studied words in the development lexicon (Barnes *et al*., 2016). The literature review described how global health partnerships were either formal or informal (Rushton and Williams, 2011). Table 5 below groups my published work according to its development through 'formal' and 'informal' partnerships. This analysis reveals that formal partnerships were established in response to the resolutions of high-level country stakeholders, with documents created by these partnerships securing the cognitive architecture (Schiffman and Smith, 2007). However, informal partnerships were constituted more like coalitions (Green, 2013) and concentrated on presenting innovative ideas. These forms of partnership are examined in more detail in the following sections.

Table 5: Publications Grouped by Type of Partnership

Publications resulting from Formal Partnerships	
Partnerships constituted by Ministerial resolution through the Pacific Vital Statistics Strategy	• Schmider 2010. Advocating for civil registration: Guide to developing a business case for civil registration. • University of Queensland, Australia University of Queensland 2012a. Country Report: Mongolia CRVS assessment and health information systems training. May 2012, University of Queensland, Australia • University of Queensland 2012b. Country Report: Philippines CRVS improvement and strategic planning. July 2012. University of Queensland, Australia • University of Queensland 2012c. Country Report: Cambodia CRVS improvement and strategic planning. August 2012. University of Queensland, Australia • WHO 2012. CRVS Resource Kit. WHO Geneva
Partnerships constituted under the Global Strategy for Every Woman, Every Child	• WHO 2013. Translating Recommendations into Action: Report on Progress Towards Implementing the CoIA Recommendations • WHO 2014. Implementing the Commission on Information and Accountability Recommendations: 2014 Progress Report • WHO 2015. Implementing the Commission on Information and Accountability Recommendations: 2015 Progress Report
Regional partnerships under the direction of Ministerial resolutions	• WHO UNECA ASSD 2015. Improving Mortality Statistics in Africa: Technical Strategy 2015 – 2020. UNECA Ethiopia.
Global partnership structured through WHO	• Boerma, T., Harrison, J., Jakob, R., Mathers, C., Schmider, A., Weber, S. 2016. Revising the ICD: Explaining the WHO approach. Lancet Vol 388 issue 10059
Publications resulting from Informal Partnerships	
Partnerships formed explicitly around the innovation agenda	• WHO 2013a. Strengthening Systems through Innovative Approaches in the Health Sector: Guiding Principles. WHO Geneva • Canada International Development and Research Centre 2018. Global State of CRVS. Canada IDRC, Ottawa, Canada. • Jackson, D., *et al*. 2018. CRVS in health systems. Bulletin of the World Health Organization 2018:96
Partnership formed explicitly to create the global scaling-up plan	• World Bank-World Health Organization 2014. Global Scaling Up CRVS Plan 2015-2030. World Bank, Washington.

Formal Partnerships

Formal partnerships, in my experience, were most successful at the regional level in Africa and Asia-Pacific. Ministerial resolutions created legitimacy for these partnerships by publishing a unifying narrative, establishing the history and a story of CRVS. Published resolutions also documented the political commitment to CRVS as a development issue. For example, the Ministerial CRVS resolution created during the Ebola outbreak in Africa ran to five pages, with twenty-three points in the preamble and only ten action points. Ministers and their officials drafted the resolution preamble carefully to embody all development agendas, from human rights to health and child protection (UN Stats, 2015). In this way, ministers ensured that development agencies could not work outside of the resolution. Similarly, Pacific Ministers formally requested that development partners create a formal partnership mechanism (SPC, 2010). This partnership influenced the joint publication of five documents in my published work, as noted in Table 5. It was so successful that we were formally recognised with an Australian Government Award in 2012[1].

As I experienced it, there was a close relationship between countries and development partners at the regional level. CRVS resolutions were the critical means through which countries expressed their requests of regional development agencies. Regional development partners respected these Ministerial resolutions and acted upon them. The Ministerial legitimacy represented in the resolutions was a strength for the regional partnerships, with agencies empowered to supported countries to undertake comprehensive reviews and other programmes of work based on these documented regional resolutions (WHO, 2013 in Annex A.5). These regional structures played an essential translational role by working closely with their countries on their development challenges and needs. Rather than simply translating from the global 'top down', regional actors were valuable in helping the global development community understand CRVS from the 'ground up'. I enjoyed working with my regional WHO and UN colleagues and highlighted their work in annual reports at WHO, comparing it to the lack of progress globally (WHO, 2013, 2014, and 2015 in Annexe A.5; WHO 2013a in Annex A.4).

These formal regional partnerships were also crucial to influencing global policy actions for CRVS. There was no global Ministerial resolution about CRVS. Consequently, there was no attention to CRVS as part of the global health agenda for many decades. However, resolutions demonstrated demand for action from Member States, something to which WHO would respond. With no resolution at the global level,

[1] The NATSTATS Award was issued by the Australian Bureau of Statistics to Pacific development partners supporting the Pacific Vital Statistics Strategy (2010).

I instead collated regional commitments, counting regional ministerial commitments and contrasting regional energy with the inertia of the global actors on the CRVS agenda (WHO 2013 in Annex A.4).

There is a surprising lack of analysis in the global health literature about regional health actors' role, coordination, and purpose. For example, the WHO has six regional offices, each with political structures and elected regional committees (Hanrieder, 2020); however, these are rarely examined for their role in global policy processes. Working in WHO headquarters – having come from a federal government system in Australia – I assumed that regional offices should have an influential role in global health policy development because they work more closely with countries. However, at headquarters, there seemed a disregard for the role and contribution of the regional offices. The elite discourse at headquarters underscored this divide. Headquarters discourse was often shrouded in deep, technical, scientific, and medical language, unintelligible to a lay audience. As I experienced, this created an intellectual and language barrier between global and regional levels. As such, partnerships between these levels were challenging because they work in different development 'languages'. As a colleague from Asia remarked, senior WHO regional and country officers were invited to headquarters to hear 'on high' messages once a year. However, they could often not understand what their headquarters colleagues were saying.

Informal Partnerships

In contrast, informal partnerships for CRVS spanned these boundaries and formed around innovative ideas. For example, WHO and the World Bank established an informal relationship in 2014 to produce the *Global CRVS Scaling Up Plan* (World Bank and WHO, 2014 in Annex A.6), dedicating an entire section to new ideas, as previously described in Chapter 3. Beyond new ideas, however, the informal partnerships were a means to reach beyond elite technocrats to search for ways to create change (Cornwall, 2008 p8). For example, the World Bank WHO document (2014 in Annex A.6) was considered 'informal' in the UN framework. As such, the partnership had the freedom and opportunity to reimagine the global CRVS as a global issue without formal constraints about agency mandates and standards. Using this freedom, my World Bank colleague and I structured the Plan to include a range of development partners, not only those agencies that had neglected the CRVS mandates.

A key feature of our work was reimagining the development landscape as an inclusive, rather than an exclusive, domain. We ensured each development partner could see their mandate within the Plan, referencing *every* global policy relevant to CRVS from the MDGs and SDGs to the Global Strategy for women and children and the Convention on the Rights of the Child. The broad consultation process included global UN agencies and African and Asian UN agencies, donors and development banks, NGOs, and countries including Bangladesh, Burkina Faso, Ethiopia, Mozambique, and the Philippines (World Bank and WHO, 2014 in Annex A.6). This inclusive process mirrored a range of new consultation and

participatory processes used for the SDGs (Fukuda-Parr and McNeill, 2019). To me, the inclusion and participation of so many actors was a vibrant counterbalance to the exclusive processes of the UN and WHO, which had resulted in stagnancy and neglect of the CRVS agenda.

As my CRVS work at WHO progressed, informal partnerships became a mechanism through which WHO could engage multisectorally with NGOs and other international organizations. WHO was able to engage in creative discussions with other partners such as UNICEF. A highlight was our joint publications focusing on innovations for women and children as part of CRVS improvement (Jackson *et al*., 2018 in Annex A.10; WHO, 2013a in Annex A.4).

Summary

Formal and informal partnerships were crucial to the social processes of development for CRVS. Formal regional partnerships increased country awareness and commitment to CRVS as a development agenda and reciprocally provided evidence for global policy. In contrast, informal global partnerships focused on refreshing the ideas and social processes for CRVS as a modern development agenda. While there were advantages and disadvantages to both types of partnership, a valuable insight from this analysis is that *both* forms were necessary to shape the broader CRVS development agenda. However, these formal and informal activities, and the knowledge they produced, cannot be understood independently from their relationships with power (Foucault, 1980), as explored in the following section.

5. International Development: Understanding Power and Knowledge

The final research question for this thesis is: How do development actors use knowledge and power to shape international practice in the field of CRVS? As shown in Chapter 4, partnerships were vital to the social processes of knowledge development during the emergence of CRVS as a more prominent global agenda. However, partnerships were also the mechanisms where I experienced and observed complex power relations (Foucault, 1983, p327). This section examines my experiences and observations about the relationship between knowledge and power through the ensemble of institutions and power strategies used in development (Gaventa, 2006) using Gaventa's framework to analyse ***forms*** of power (visible, hidden, and invisible), ***spaces*** for power (closed, invited, or claimed), and ***levels*** of power (global, national, local) (Gaventa, 2019). It systematically considers my experiences of, and observations about, the use of knowledge and power, ranging from my own use of knowledge and power to the use of knowledge and power in key relationships established by my body of work.

Owning Power and Knowledge

As an analytical autoethnography, my analysis should first offer insight into my own power as a development professional (Mosse, 2013) to understand myself as part of the power picture, influencing roles, values, and strategies for change (Gaventa, 2019, p15). The authority of international organizations such as WHO is derived from the agreement by states to administrative power and functions; the accrual over time of responsibilities, funds, and mandates; and the creation of epistemic authority (Stone, 2020 pp2-3). In my global role, I had a level of visible positional power grounded in WHO's global epistemic and normative role (McInnes and Lee, 2012).

A critical aspect of my positional power was the production of knowledge. WHO produces policy knowledge using publications, reports, and other forms of data (Stone, 2020 p52). As the global CRVS focal point, I could use my positional power to expand knowledge and research and publish these in guidance and technical documents with the WHO logo. For example, I created space for innovative approaches to health and CRVS, inviting other agencies into this space to collaborate on an early publication to improve CRVS in developing countries (WHO, 2013a in Annex A.4). In addition, I generated research and evidence from seventy-five countries to make recommendations about global agenda development and cooperation (WHO, 2013, 2014, 2015 in Annex A.5).

However, deeper theoretical analysis helps to go beyond simply critique of my positional power. My positional power options and strategies (Gaventa, 2019) were shaped by the fact that WHO does not have the legal power to act *upon* countries or other development actors (Foucault. 1983 p344). The

WHO cannot officially coerce countries or other development actors to accept published epistemic and normative knowledge. The WHO has only the power to use knowledge and position to *influence* others, with documents being the necessary means of exercising this influence. My power, therefore, was focused on structuring the field of action (Foucault, 1982, p341) by inviting other development actors to participate in the global knowledge development process. I secured this influence through publications, making innovative ideas part of the cognitive architecture (Smith and Schiffman 2007).

Further, as Crewe and Axelby noted, development actors use their knowledge and power to shape practice (2013, p43). Using influence and invitation (Gaventa, 2019), documents I authored at WHO between 2013 and 2018, included in this PhD by publication, became the visible means of persuasion. I openly used documents to influence a more significant role for WHO within the CRVS agenda. I positioned the WHO's health mandate equally alongside the mandates of other global actors such as UNICEF and the UN statistics agency, by documenting examples of health innovation for CRVS (Canada IDRC, 2018 in Annex A.9; Jackson *et al*., 2018 in Annex A.10; UNICEF, 2017;WHO, 2013a in Annex A.4). As I argued in my 2013 publication, the health sector was a beneficiary of CRVS systems; however, it also played a role in contributing to and improving CRVS systems (WHO, 2013a in Annex A.4). Therefore, the power I was seeking for WHO was not hierarchical power; it was the power of reciprocity.

This first document (WHO, 2013a in Annex A.4) and consequent progress reports I authored (WHO, 2013; WHO 2014; WHO 2015 in Annex A.5) were formal publications that established WHO's role in this agenda. For example, the publication on innovation (WHO, 2013a in Annex A.4) was published as formal WHO guidance, documentation with normative standing amongst global development partners. However, it was not exclusive to WHO. The document also carried the logos of the UNICEF, the World Bank and the aid agencies for the USA and Canada. Therefore, the document represents a new ensemble of strategies and actors that made knowledge development and relationships *visible* (Gaventa, 2006; Gaventa, 2019). This publication was, in hindsight, one of the most valuable documents in terms of establishing this new ensemble. It required the use of WHO's *visible* powers (Gaventa, 2006) – its formal role in norms and standards development - to guide and influence this ensemble.

Development Agencies: Power, Knowledge and Relationships

Previous analysis shows that my partnership style was collaborative, inviting other development actors to participate in WHO's knowledge development process. However, as Foucault noted, where humans are placed in relations of production, they are equally placed in power relations that are very complex (1983, p327). Across my experience, there were complex power relations in the development 'marketplace' where knowledge is brokered (Green, 2013).

Partnerships described in Chapter 4 seem simple. However, in practice, these partnerships were extraordinarily complex. For example, historical antagonism and competition between WHO and the UN statistics agency impacted our relationships. Knowledge mandates for CRVS were divided across these two organisations: the UN statistics agency 'owned' statistical standards for CRVS, and WHO 'owned' the ICD. Each agency's published standard visibly demonstrated each agency's power and mandate (Gaventa, 2019). Both standards were essential to CRVS as a long-standing development agenda, as shown in the CRVs tree. Accordingly, these agencies should have had a close relationship. In fact, there was a formal, long-standing agreement for cooperation signed in 1948 (UN and WHO, 1948).

However, the WHO-UN relationship was the most challenging inter-agency relationship I experienced across my work. The two agencies barely spoke to one another. The formal relationship was awkward and sometimes unpleasant, with an evident struggle for primacy. Moreover, we had significant differences in our use of forms and spaces for power. My approach as a WHO representative was to be *visible*, *participatory*, and use positional power to create new relationships. (A colleague, with a similar style, calls this the 'Pollyanna' approach). Frustratingly, the UN approach was *visible* yet *closed* (Gaventa, 2019). The UN agency openly exercising its power in its closed spaces into which the WHO was 'invited'. For example, every year, there was a global statistics meeting hosted by the UN agency. My WHO colleagues recounted their fear of attending the meeting because UN colleagues demeaned them publicly. This observation appears correct on reading the documents from the annual meeting in 2013. In this document, the UN visibly exerts its power in its documented decision-making processes (Gaventa, 2006). It reprimands the WHO, expressing concern about the 'inadequate consultation and coordination' between WHO and the international statistical community; criticising WHO's engagement with other international agencies; and expressing 'deep concern' about WHO oversight of technical projects (UN Statistical Commission, 2013, p16). There appears little diplomacy in this document. Whether WHO's shortcomings are justified or not, the very fact they were published, rather than negotiated in a side meeting as would (in my experience) be more usual, appears a deliberate expression of power by the UN over WHO at that time. This published critique is certainly not in keeping with the long-standing agreement for cooperation between these agencies, dating since 1948.

This public and dominant flexing of power and knowledge between the agencies made the CRVS working relationship challenging. By nature, I am collaborative and had significant success in developing both formal and informal relationships across my body of published work. I did try to improve the relationship between the WHO and the UN statistics agency using informal approaches. For example, I invited my UN colleagues to a CRVS consultation meeting in 2013 and encouraged their contribution to the plan. The WHO even paid for their flights. There were some successes between us: the WHO proposed that the UN statistics agency lead a global collaborating group, which they consequently created. I was invited to some (but not all) of their technical meetings. However, I also experienced

displays of power from this UN agency's representatives. For example, I was openly berated and humiliated in an international meeting in 2018 for suggesting that change and innovation were essential to modernising global standards. I was often excluded from their meetings. The challenges of cross-agency work are rarely documented. However, they are influential in how development issues are actioned (or, conversely, *not* actioned). As a colleague recounted, a directive had to be issued by a UN Deputy Secretary-General to request UN agencies, including WHO and the UN statistics agency, to work together on the legal identity agenda strongly related to CRVS (UN Statistics, 2021).

It was difficult to anticipate and challenge this elusive use of power. It was sometimes *visible*, sometimes *hidden* (Gaventa, 2019), and sometimes published. To my disappointment, the relationship between WHO and this UN agency did not improve during my time on CRVS. One senior African colleague noted that the historically poor relationship could not be healed, not even with my 'magical diplomatic superpowers'. Taking an opportunity at an African meeting, I approached one of my UN colleagues about improving the poor working relationship between our agencies. This colleague's immediate response was that relations would only improve if the WHO 'paid homage' to the UN agency.

It is important, however, to go beyond the critique of the poor relationship between these agencies. This challenging relationship, in fact, positively impacted other ways. One of my main motivations for seeking new and informal partnerships with UNICEF and World Bank was to find a way of moving around this long-standing stalemate between WHO and the UN statistics agency. While there was initially competition between WHO and UNICEF about their overlapping health agendas, I invited UNICEF to participate in an early body of CRVS-health work. From there, we painstakingly renegotiated our relationship using knowledge development and documents (Jackson et al., 2018 in Annex A.10; WHO, 2013a in Annex A.4). Documents were the diplomatic vehicles through which these new relationships were negotiated. For example, I was invited by UNICEF to CRVS workshops in Africa in 2014, and in 2016 was also invited to collaborate with colleagues from UNICEF headquarters on an original approach to CRVS innovation, which was later published (UNICEF, 2017). Invitations into claimed spaces (Gaventa, 2019) and knowledge development through documentation proved crucial to this emerging relationship. WHO and UNICEF signed a formal collaboration agreement in 2018, showing the advances in our relationship over time (UNICEF and WHO, 2018).

Documents were key to building new relationships and partnerships between the WHO and the World Bank, for example, the *Global CRVS Scaling Up Plan* (World Bank WHO, 2014 in Annex A.6). I was invited to contribute to a new global plan led by the Bank and invested months of effort researching, consulting, and writing the Plan with the World Bank. However, when it was released, the logos on the official

report included only the logo of the World Bank[2]. Although *invited* into a new space, the knowledge we developed was *claimed* by the Bank (Gaventa, 2019). The issue of logos caused great consternation at senior levels inside WHO, with accusations of deliberate exclusion of WHO by the Bank and allegations about the appropriation of intellectual property.

This issue of logos was an example of how knowledge exists in a highly competitive development 'marketplace' for knowledge (Green, 2013). In practice, logos represent ownership of knowledge as intellectual property in the international development landscape. For example, the WHO's very existence relies on creating intellectual property ('norms and standards') for global health issues. Thus, to the WHO, placing logos on documents is a display of intellectual ownership and contribution. However, in the Global Scaling Up Plan example, intellectual ownership was not brokered (*ibid*); rather, it was *claimed* by the World Bank (Gaventa, 2019).

This issue over the logo put me in an awkward position between our agencies. However, I had a close working relationship with my World Bank counterpart. I was, therefore, comfortable requesting the inclusion of the WHO logo. In response to my request, the Bank provided a summary copy of the *Global CRVS Scaling Up Plan* incorporating our logo, which we uploaded on the WHO website[3]. They also included the words 'World Bank | WHO' on the front cover of the official version (World Bank WHO, 2014 in Annex A.6, Cover Page). Unfortunately, however, the WHO logo was never incorporated into the final publication. The lesson is that I could have spent more time negotiating at the outset how our document would identify agencies, authors, and contributors. Logos on documents signify partnerships and relationships at the point in time (Okeke, 2018), as well as knowledge and contribution.

Elite Power and Knowledge: Science and the Global North

So far in this thesis, I have focused on the knowledge and power in relationships external to WHO – for example, with other development agencies. However, noted in the literature review, organisations such as the WHO create scientific knowledge through their functions and epistemic communities (Stone, 2020). As such, knowledge and power can also be embedded in relationships *internal* to WHO. The ICD is one example generated through WHO scientific knowledge processes and epistemic communities (Roberts *et al*., 2015). The ICD is necessary to classify disease and deaths in the population. As I had published in Australia, these data determine disease burden and life expectancy within a population (ABS, Cat 3303.0 2010; 2011; 2012; Queensland Government, 2008; Queensland Government, 2009). In

[2] You can see the World Bank version here: https://openknowledge.worldbank.org/bitstream/handle/10986/18962/883510WP0CRVS000Box385194B00PUBLIC0.pdf?sequence=1&isAllowed=y

[3] You can see the World Bank-WHO version here https://www.who.int/healthinfo/civil_registration/WB-WHO_ScalingUp_InvestmentPlan_2015_2024.pdf?ua=1

turn, these data contribute to government and national health policies, plans and targets, as shown in the CRVS tree (Figure 3, previous) (Schmider, 2010 in Annex A.1).

With this deep and applied understanding of the value of the ICD to health, I worked with data scientists in many developing countries to improve their use of the ICD (University of Queensland, 2012 a; 2012b; 2012c, in Annex A.2). However, the map we published in the *Global CRVS Scaling Up Plan* showed that the ICD was only implemented fully in thirty-five of the 196 WHO Member States; and was not implemented or used for the cause of death statistics in most developing countries (World Bank WHO, 2014 in Annex A.6). This map revealed an uncomfortable truth for the WHO. As I debated with a WHO colleague: the ICD could not be considered a global 'standard' if it could not be implemented in most Member States.

Here, anthropological understandings about the social processes of development, power and knowledge explain why the ICD was not widely implemented. Crewe and Axelby argue that development professionals establish hierarchies of knowledge and create a 'rule of experts' and, in doing so, silence certain voices and exclude alternative modes of thought (2013, p153). These spaces are open only to experts and closed to others, with discussions and decisions made behind closed doors. In these spaces, the power is *hidden*. Specific issues or voices are excluded from the agenda, creating an environment where issues and inequities go unquestioned (Gaventa, 2019). This type of power is especially dominant in the scientific epistemic and normative communities at the WHO, where 'expert' committees entrench dominant paradigms and exclude others, including those for whom the evidence base is being used (Lambert, 2006).

In fact, the WHO's authority is derived from the creation of scientific epistemic authority (Stone, 2020 pp2-3). In the case of the ICD, hierarchies of knowledge were created by scientific and medical experts in a global network of committees and collaborating centres formally established to advise WHO about ICD content. Further, the WHO requirements for these committees entrenched inequality. The WHO requires that members of these committees and collaborating centres be of high scientific and technical standing at national and international levels; they occupy a prominent position in the country's health, scientific or educational structures; and are stable in terms of funding (WHO, 2018). These requirements effectively exclude developing countries and their agencies from participating in ICD processes by virtue of their inability to finance a collaborating centre or participation in global elite processes. As a result, all committees comprised high-income countries and ICD collaborating centres established in those same countries (Roberts *et al.*, 2015; WHO, 2020a). This exclusion creates a hierarchical structure between the 'global north' and the 'global south', embedded in the processes of knowledge production. For a time, I was, in fact, one of these high-income country representatives. Before working at WHO, I was an Australian representative and voting member on the WHO Mortality Reference Group between 2010-2012. However, not having a deep background in the ICD put me at a disadvantage, as I often

could not participate in the deep scientific discussions, even though statisticians like me were responsible for producing the bulk of the world's mortality statistics.

The entrenched scientific elitism and the consequent inequity in global health policymaking processes exist on a broader scale than just for the ICD. The WHO relies widely on 'WHO collaborating centres' for expert knowledge and ideas in its normative work (WHO, 2018). However, this knowledge process is biased towards high-income countries, with more than 60% of the 840 committees established in Europe, Australia, Japan, Korea, and the USA. In contrast, only twenty-seven (less than five per cent) are situated in Africa, with fifteen of these located in one country - South Africa (WHO, 2020). Thus, the WHO's requirements for elite policy and scientific knowledge work in practice to entrench power and knowledge bias towards the 'global north' in WHO policymaking processes.

Working on the CRVS agenda at the global level, as I experienced it, the ICD's entrenched, elitist approach had no balancing voice or process to include developing countries. Working in the Asia- Pacific and Africa between 2011 and 2017, I often documented the challenges of implementing the ICD in developing countries (University of Queensland, 2012a, 2012b, 2012c in Annex A.2). For example, many trying to use the ICD lacked the requisite scientific background. As I described to one of my colleagues at a regional WHO meeting, the use of ICD required 'three PhDs'. As I knew from using the ICD for national statistics in Australia, significant investment was needed for the ongoing training of our statisticians to use the latest ICD. The impacts of constant scientific revisions were far more pronounced in less well-endowed health systems. For example, as we noted in our Mongolian report, doctors were often not trained how to complete the detailed ICD form, and six months of training was needed for health statisticians to master ICD coding (never mind about the frequent updates) (University of Queensland, 2012a in Annex A.2 pp15-20). We noted these same issues for The Philippines and Cambodia (University of Queensland, 2012b, 2012c in Annex A.2).

Because of this in-country experience and fieldwork, I also noted a lack of representation by developing countries in the scientific ICD decision-making processes at WHO headquarters. As a result, ICD decision-making processes were disconnected from the reality of implementation in developing countries. There was an assumption in the ICD decision-making processes that the classification could be easily implemented. However, fieldwork told us a different story. During one country visit, a WHO colleague commented that it was embarrassing to see how scientifically complicated the ICD was from the viewpoint of countries that could never hope to implement it.

I observed this bias more closely when I worked within WHO as ICD Project Manager between 2015 and 2017. At the global level, the scientific community was at war over its revision. Scientific experts in particular fields were wanted specificity and greater depth and complexity in coding, driven by attracting funding to their speciality. As our Lancet article noted, these scientific debates dominated the discussion

about ICD (Boerma et al. 2016 in Annex A.8). (2018 p2476). I saw first-hand that WHO did not actively or routinely incorporate the voices from developing countries into any ICD decision-making processes. Instead, most committees only included representatives from Australia, the USA, Canada, and Asian countries such as Japan and South Korea. Thus, the social processes underpinning the ICD were both exclusive and biased. A senior WHO colleague was shocked when I argued in an internal WHO team meeting that the ICD was created 'by developed countries, for developed countries' (my exact words). These committees, I observed, tended to generate increasingly complex technical content, the dimensions of which I noted in our Lancet article:

> *The 11th revision of the ICD … was driven by 30 committees and working groups, including 21 topic advisory groups with clinical expertise in all key areas, including neurology or internal medicine. Over 7000 revision proposals were received through an internet platform.* (Boerma *et al*., 2016 in Annex A.8 p2476)

Foucault's observation about the reciprocal and dynamic relationship between power and knowledge is highly relevant in this example. Ever-deeper technical knowledge and scientific language created power for high-income countries within the ICD process, effectively excluding other countries from participating. Beyond the global discussions, however, as I knew from my Australian experience, it was hard to 'catch up'. Reciprocally, the greater exclusive power of these committees led to the generation of ever more technical knowledge.

However, it is important to go beyond a critique of the scientific communities. In fact, the responsibility for equitable and accessible processes for global norms and standards lies with the WHO. It is the WHO's role to ensure inclusivity in global policymaking processes. In the case of the ICD, WHO entrenches the power of high-income country knowledge in its decision-making processes. As I observed, significant amounts of money were spent on global conferences and meetings to develop ever-more-technical knowledge for a classification only implemented in around thirty countries in the world. Participants were oblivious to the lack of global implementation. Not once did I see a report by WHO at these meetings that outlined which countries were using ICD and which were not. WHO and other international organizations are often criticised for enshrining elite, often western, ideology (Stone, 2020). These meetings served that purpose. However, there is a downside to entrenching elite knowledge: self-perpetuating knowledge processes may become detached and ignorant. The result was that many experts were giving their time to processes that were not serving a global purpose, as shown in our published maps (World Bank WHO, 2014 in Annex A.6, Appendix 3).

In my experience with the ICD over multiple years, at various levels, not once did WHO propose to establish the voices of developing countries within these committees or otherwise improve the diversity

of representation. Within the broader CRVS agenda, we sought to counterbalance this knowledge bias by focusing on technical knowledge *by developing countries, for developing countries,* paying attention to the everyday**,** non-elite knowledge (Ingram, 2020). The post-Ebola technical strategy sought to improve knowledge development processes to address this power imbalance (WHO UNECA ASSD, 2015 in Annex A.7). For example, I led an ICD expert consultation for the post-Ebola strategy focused on African and the Middle East, which was so popular that more than ninety experts attended, often at their own cost.

The experience of ICD illustrates a critical point: there is a geography of knowledge (Ingram, 2020). Power, knowledge, and financial privilege give actors from high-income settings a stronger voice in global health processes, influencing 'what counts as evidence' (Lambert, 2006; Malone *et al*., 2004). As Crewe and Axelby argue, the creation and maintenance of hierarchies of knowledge underpin the 'rule of experts' (2013 p153). WHO processes entrench this geography of knowledge and power, in my experience, pointing to the need for global health professionals, including myself, to pay more attention to *whose ideas and voices are included in global policy processes and whose are excluded*. Policy approaches need to shift from using knowledge to exclude low-income entrants to using knowledge to invite entrants into claimed and inclusive spaces (Gaventa, 2019).

From an anthropologist's perspective, this power imbalance can be addressed using fieldwork to highlight development shortcomings and illuminate, challenge, and extend thinking (Venkatesan and Yarrow, 2012). Eyben (2013) argues that fieldwork has been a key aspect of her practice as a development professional:

> *I used to make regular visits of a few days to different parts of the country with no other purpose except, as I explained at the time: 'to deepen our knowledge of the work of social and economic institutions at the local level, to understand more about the lives of poor people and their communities and to consider the links between micro-reality and macro-level policy and action….. I have since been part of a campaign to persuade staff of international aid agencies to take time out of their offices to spend a few days as participant observers in local communities in aid recipient countries.* (Eyben, 2013 p139).

Similarly, knowledge developed from my fieldwork with country counterparts pointed the way towards innovation. In one example, I visited an Asian country on a CRVS field visit, meeting with a hospital data manager who had created a simplified version of the ICD. This simplified ICD enabled the hospital to collect precious data for monitoring diseases and hospital services. Its value is demonstrated in its continuous use within the hospital since 1998. This visit was a real highlight of my time at WHO. I closely observed the care and attention that this manager and the hospital's data team put into

collecting precious data using the ICD. Their working quarters were small, located in the basement of the old colonial hospital. However, ICD-coded data were carefully handwritten into books stored in formal order on shelves on the wall. These ICD data were then meticulously transcribed into one of the oldest computers I had ever seen, which used large floppy disks from the 1980s. Finally, the manager showed us the tables they could generate from these data, analysis which identified necessary services, staffing levels and supplies for the hospital. My WHO colleagues and I, on that visit, were given a published copy of the simplified ICD they used. We knew that implementation in many countries was non-existent. This practical example showed how a simplified ICD could be used as a starting point in countries that would not otherwise use the ICD. We considered this an innovation from the 'ground-up'.

In the example of the ICD, power and knowledge were used to challenge and adapt elite processes, creating new rules of the game (Gaventa, 2019). We knew that there would be resistance to a simplified ICD at WHO headquarters and on these global elite committees, which had spent decades creating the complex ICD. However, if hierarchies of knowledge preserve the rule of experts (Crewe and Axelby, 2013), I reasoned that new knowledge could change the hierarchy. So, with like-minded WHO colleagues, I organised an internal meeting on my return to Geneva and used this simplified ICD to negotiate change inside WHO with the classification 'owners' – the WHO team looking after the ICD. We approached it as an internal business case, deliberately using a *closed* power strategy to move around the elite committee processes. While the committees used exclusive scientific or statistical language, we used visualisations and political and moral language. We showed the World Bank and WHO maps to show the limited ICD implementation and presented the simplified ICD proposal as a potential political solution for WHO to the lack of ICD implementation.

The Ebola outbreak was a powerful narrative within this internal business case because it had revealed that African countries could not collect ICD data for cause of death. We argued that, given the tragedy of Ebola, the WHO was ethically bound to create a global standard that was both fair and accessible to all countries. In the end, we achieved success with the consensus that we would create a simplified ICD. Nevertheless, to save face for the WHO experts, we still compromised. We agreed not to use the word 'simplified', which (apparently) undermined the significant work that had made the ICD. Instead, we agreed to use the term 'Start-Up List'. This term reduced the elites' concerns and neatly worked with the CRVS innovation narrative emerging from developing countries. This 'Start-Up List' is now in its second version (WHO, 2018a).

Policy Windows: Knowledge, Power and Seismic Shifts

Global policy windows offer the opportunity for networks to develop strategic knowledge to convince political leaders to act (Schiffman and Smith, 2007). Thus, the state of knowledge at these points in time is critical. WHO's knowledge is built on its mandate for scientific 'normative' knowledge development to support its role in providing leadership on matters critical to health. Its knowledge development activities support the global scientific agenda, set norms and standards, are used to articulate ethical and evidence-based policy options, provide technical support, and monitor health trends (WHO, 2017).

In contrast, international organisations such as the World Bank produce broad-scale economic knowledge focused on development financing. In addition, the Bank has substantial in-house research expertise. Calling itself the 'knowledge bank', it can produce research and policy knowledge through publications, reports, and other forms of data (Mosse, 2013; Stone, 2020 p52). However, the Bank is often criticised in global health and anthropological literature for using its knowledge and power to promote western ideology (Stone, 2020). It is especially criticised for using knowledge and financing power to introduce neoliberal reforms. For example, the World Bank made loans to the health sector in many countries, making these loans conditional on increased privatisation, decentralisation, and fee-for-service payments (Blume, 2020). These loans have weakened country health systems and reduced access to healthcare (Schrecker, 2020). Many authors argue that the Bank's actions have also weakened other actors such as WHO (Harman, 2012; McInnes and Lee, 2012; McInnes *et al*., 2020; Youde, 2013).

I became involved in using the Bank's expertise in knowledge development at the end of the MDGs when a policy window opened after global targets for women and children were not met (World Bank, 2015). In response to this policy window, the World Bank proposed creating a new Global Financing Facility (GFF), which included $100m in funding for CRVS. This funding had been provided by the Canadian Government, based on the work leading to the Global Scaling Up Plan (Canada IDRC, 2018 in Annex A.9). As a result, I was invited by the Bank to contribute to the Business Plan for the GFF. Given my CRVS work to that point, of course, I accepted.

Development business cases are an important, if understudied, aspect of the international development approach. I knew the policy use of business cases very well, having worked in treasury departments in Australia. As such, I knew business cases could influencing new policy directions. For example, I had recommended that countries use business cases to make a case for change (Schmider, 2010 in Annex A.1; WHO, 2012 in Annex A.3; WHO UNECA ASSD, 2015 in Annex A.7). Examining the process for creating the GFF Business Case (World Bank, 2015) provides an important illustration of how international development business cases use power and knowledge to create a seismic structural shift in the development field. Firstly, the GFF Business Case built upon other prior knowledge that I had published in partnership with others, especially the *Global CRVS Scaling Up Plan* (World Bank and WHO, 2014 in Annex A.6). Secondly, creating a new framework for knowledge helped secure a new role for

the Bank in global health. For example, the Bank created new governance arrangements and a discrete organisational structure to support the GFF. Finally, the Bank strengthened its role by creating hierarchical financing rules for the GFF, which tied donor funding to the World Bank GFF and tied countries to the World Bank GFF process. The Bank created c*onditional contracts* with countries to control the type of funding for which developing countries could apply (World Bank, 2015). 'Conditionality' is formally defined as the application of 'conditions' to agreements between the Bank and developing countries about finance or debt relief (Schrecker, 2020, pp471-472). For CRVS, these conditional requirements involved countries taking out a credit/loan from the Bank for their CRVS system *before* they could get a grant (World Bank, 2015 p4). This GFF conditionality secured the Bank's power under the new arrangements. A GFF business case team member used a 'fast food' analogy to explain it to me. In fast-food businesses, burgers are only offered as part of a 'conditional' package, including fries, whether the customer wants fries or not. GFF grants for CRVS activities (the burger) could not be accessed unless the country also took out a loan with the World Bank (the fries).

Here it is crucial to go beyond critique. As Foucault pointed out, strategy is defined by the choice of winning solutions (1982, p346). The GFF example shows how the Bank used knowledge as part of a winning strategy to create a more significant role for itself in global health; an approach it has used over some decades, starting with the publication of its *Investing in Health* report in 1993 (Kenny, 2015; Schrecker, 2020). The Bank used knowledge developed into a business case to attract funding from donors for the GFF *and* secure its health role by funding country health programmes in a new way. This approach confirms the power of the flow of development finance shown in Figure 1 (University of Washington, 2018). As Foucault theorised, the Bank exercised its power by creating knowledge and reciprocally used this knowledge to generate power (Foucault, 1980).

This use of knowledge and power created a significant, seismic, shift in global health. Firstly, the Bank became a more significant global health actor. Never previously involved in CRVS, the Bank was suddenly the world's most prominent CRVS actor by virtue of its control of the flow of $100m in development funding (Canada IDRC, 2018 in Annex A.9). Secondly, it used this new power to shape its role in global health, starting at the country level. In a final act of structural power, the Bank then excluded other global health actors with whom it had worked on the GFF Business Case. When the GFF business plan was finished, our CRVS team was disbanded. There was no role for our team in the created GFF processes. We were not alone in being excluded. I attended a meeting in Nairobi in early 2016, convened by UN agencies to discuss their exclusion from GFF operations at the country level. A pivotal point of discussion was how the Bank had created exclusive processes for the GFF. GFF processes bypassed much of the agreed global health coordination infrastructure. Further, confidentiality agreements created between the Bank and countries excluded any development agency from these discussions. Country representatives expressed discomfort at non-disclosure requirements precluding

them from speaking to any other agency about Bank negotiations. The feeling at these meetings was that development partners were deliberately excluded by the Bank (PNMCH, 2016; RHS, 2015). Finally, it is a critical point that I did not anticipate the use of any of these forms of power, and nor did my WHO colleagues. The result was that the Bank created a new space in global health, legitimating its relationships between donors and countries and creating a structural shift among global health actors. In effect, the Bank moved confidently into global health by building its health role (Benetar *et al*., 2020; Kenny, 2015; Sparke 2020).

The example of the GFF is one of the most complex of my experiences in terms of the use of power and knowledge. There were multiple forms of power at play in an environment that was (perhaps deliberately) unclear. There were *hidden* forms of power, for example, the confidentiality agreements between the Bank and countries. In addition, there were *invisible* forms of power, for example, conditionality requirements. There were shifting *spaces* in which power was exercised. For example, there were *closed* spaces between the Bank and countries, *claimed* spaces such as the GFF Business Case, and *invited* spaces such as the space formed during the GFF business case (Gaventa, 2019). Power *levels* also shifted (Gaventa, 2019), with global partners actively collaborating on the Business Case but excluded from national discussions.

Going beyond critique, however, these actions can be analysed from a more strategic perspective. For example, the Bank orchestrated its use of power and knowledge in a *sequenced* way, first using 'invisible' power to create a new business case with internalised ideologies, norms, and values, leading to acceptance of the proposed new 'status quo'. Second, it used 'hidden power' to keep certain voices out of the decision-making process, creating new rules of the game. Finally, it created a closed space to secure its new global power, creating a direct relationship with donors and countries that bypassed traditional development relationships (Gaventa, 2019 p9). Strategy is, indeed, defined by the choice of winning solutions (Foucault, 1982). There are further strategic insights to be drawn from this experience. In fact, the Bank was able to act in this space using power and knowledge because there was a *development void*. Foucault argued that power is enabled where a 'system of differentiation' exists; describing a space where one actor can exercise power on others due to differences in law, status, and privilege, knowledge and competence, economic differences, or shifts in the processes of production (Foucault, 1982 p344). Much of my work on CRVS had exposed this 'system of differentiation', identifying the inactivity of global CRVS agencies (WHO, 2013 in Annexe A.5) and exposing the lack of implementation around the world (World Bank WHO 2014 in Annex A.6). My work created informal partnerships emerged to work around this void. Using power and knowledge, the Bank created a new and powerful structure in this void. It is, therefore, a final and essential point for this thesis that development professionals shape development agendas (Crewe and Axelby, 2013) both through *action* and *inaction*.

Summary

As this section shows, knowledge and power are critical aspects of the social processes of international development, with Foucault's theories about the relationship between power and knowledge have proving insightful for contemporary analysis of international development processes.

Analytical autoethnographic methodology linking empirical understanding to theoretical frameworks has proven fruitful in going beyond anthropological critique and revealing deeper insights into the relationships between power and knowledge. Gaventa's power analysis helps identify the complex permutations of knowledge and power across space, place, and form (Gaventa, 2006, Gaventa, 2019).

However, it remains the case that few documented examples exist analysing power and knowledge strategies in international development. Therefore, from the viewpoint of contemporary development professionals, there remain open and unanswered questions about power (McInnes and Lee, 2012), a potential focus for future research.

Conclusion: Knowledge, Power and Productivity

Knowledge and power have an important relationship in international development, as this analysis of my published work reveals. This thesis first examined my published work to understand how knowledge was developed through partnerships. As this analysis shows, development documents and partnerships create shared discourse crucial for contemporary international development practice. Partnerships were important in my work for gathering and analysing empirical information about the state of CRVS systems which, once published in high-profile interagency documents, created a body of knowledge that spurred change. Policy windows presented opportunities for partnerships to use their knowledge and shared discourse, persuading and influencing global interests (Shiffman, 2015).

The *process* of co-authoring documents was important to building these partnerships, enabling partners to develop relationships over time and align their interests in CRVS with overarching processes such as those for the SDGs. For example, in my work, a new relationship with UNICEF was negotiated through the creation of documents (Jackson et al., 2018 in Annex A.10; UNICEF, 2017; WHO 2013a, in Annex A.4), and formalised in a collaboration agreement in 2018 which I helped to author (UNICEF and WHO, 2018). As such, analysis of my published work reveals the importance of development documents to establishing *new* social processes for international development.

As my body of published work progressed, I developed a deeper understanding through my fieldwork about the importance of including a greater range of voices into these high-profile development documents. For example, the perspectives of developing countries had been excluded from technocratic policy-making discussions for the ICD, resulting in norms and standards that were only appropriate for the most well-resourced countries. In contrast, the Global Strategy for CRVS was developed in consultation with selected developing countries (World Bank WHO, 2014 in Annex A.6). The new post-Ebola technical strategy was developed 'by African countries, for African countries', directed from an African Ministerial resolution, written with African partners, and endorsed by African country representatives and experts. These voices helped revitalise CRVS as a modern international development agenda by reaching beyond the elite technocrats to identify new ways to create change (Cornwall, 2008).

Examined in Chapter 5, development actors routinely use knowledge and power to shape development activities (Crewe and Axelby, 2013). Therefore, as Foucault observed, development professionals such as myself are often placed in relationships of production and power that are very complex (Foucault, 1982). The use of knowledge and power within development relationships are rarely documented, and this thesis offers a window into the tensions and rivalries that sometimes characterise relationships both *between* and *within* international development agencies. Partnerships across my body of work were

important but complex and often challenging, as Chapter 5 shows, affecting CRVS development practice at many levels. For example, historically strained relationships between the WHO and the UN statistics agency, and the use of formal documents to embed the squabbles, perhaps explain decades of CRVS neglect. The oft-criticised World Bank used its powerful economic position to carve a new role in the global health domain, creating new knowledge and power through a Global Scaling Up Plan and a new Business Case. These empirical observations from my work reveal important power strategies used in development processes (Gaventa, 2019).

However, it is an important contribution of this thesis that using analytical autoethnography to link empirical observations to theoretical frameworks takes the analysis beyond a conventional anthropological critique of the development industry (Venkatesan and Yarrow, 2012). Foucault's theories about the relationship between knowledge and power were crucial to developing a deeper appreciation of *how* the development world changes. Taking a considered view, power and knowledge were productive across my work (Foucault, 1982). After decades of neglect, publications I co-authored, based on fieldwork, articulated micro-realities that influenced macro-level policy and action (Eyben, 2013), changing the rules of the game (Gaventa, 2019). The World Bank used its power and knowledge to fill a development void left by the neglect and inaction of the WHO and UN. From this perspective, my published work revealed the scope and scale of this void and developed non-elite knowledge to influence change.

This thesis offers fresh ethnographic insights into the world of the development professional, exploring how development actors use power and knowledge within social processes. It also confirms the contemporary relevance of Foucault's theories about power and knowledge to international development. My published work, combined with the work of many others, untethered CRVS from its decades of neglect. As a result, CRVS is now more firmly attached to the cognitive architecture of international development (Schiffman and Smith, 2007). However, it is also in uncharted territory.

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Annex: Published Works

Index for Published Work

	Reference	Contribution and Verification
A.1	Schmider, A. (2010). *Advocating for civil registration: guide to developing a business case for civil registration*. University of Queensland, Australia	Main Author. Contribution approx. 11,000 words. Verified by Dr Audrey Aumua, University of Queensland
A.2	University of Queensland (2012a). *Country Report: Mongolia Civil registration and vital statistics assessment and health information systems training*. University of Queensland, Australia University of Queensland (2012b). *Country Report: Philippines CRVS improvement and strategic planning*. University of Queensland, Australia University of Queensland. (2012c). *Country Report: Cambodia CRVS improvement and strategic planning.* August 2012. University of Queensland, Australia	Co-author. Contribution approx. 16000 words. (30%). Verified by Dr Audrey Aumua, University of Queensland
A.3 (Module 8 only)	World Health Organization (2012). *Civil Registration and Vital Statistics Resource Kit*. WHO Geneva	Co-author, Module 8 only. Contribution approx. 4000 words (50%). Verified by Dr Audrey Aumua, University of Queensland
A.4	World Health Organization (2013a). *Strengthening Systems through Innovative Approaches in the Health Sector: Guiding Principles*. WHO Geneva	Co-author. Contribution approx. 4000 words (50%). Verified by Dr Jane Thomason, HMN
A.5 (CRVS progress sections only)	World Health Organization (2013). *Translating Recommendations into Action: Report on Progress Towards Implementing the CoIA Recommendations.* WHO Geneva World Health Organization (2014) *Implementing the Commission on Information and Accountability Recommendations: 2014 Progress Report.* WHO Geneva World Health Organization (2015) I*mplementing the Commission on Information and Accountability Recommendations: 2015 Progress Report.* WHO Geneva	Co-author, CRVS sections. Contribution approx. 6800 words. Verified by Dr Jane Thomason, Health Metrics Network
A.6	World Bank-World Health Organization (2014). *Global Scaling Up CRVS Plan 2015-2030.* World Bank, Washington.	Co-author. Contribution approx. 7000 words (20%). Verified by Dr Sam Mills, World Bank
A.7	WHO, UNECA & ASSD (2015). *Improving Mortality Statistics in Africa: Technical Strategy 2015 – 2020*. UNECA Ethiopia.	Main author. Contribution approx. 13000 words (90%). Verified by Mr Raj Mitra, UN Economic Commission for Africa
A.8	Boerma, T., Harrison, J., Jakob, R., Mathers, C., Schmider, A., Weber, S. (2016). 'Revising the ICD: Explaining the WHO approach'. *The Lancet* Vol 388 issue 10059	Contributing author in peer reviewed journal
A.9	Canada International Development and Research Centre. (2018). *Global State of CRVS*. IDRC, Canada.	Main Author (80%). Contribution approx. 8000 words (80%). Verified by Dr M Kamal, Canada IDRC
A.10	Jackson, D., Wenz, K., Muniz, M., Abouzahr, C., Schmider, A., Braschi, M., Kassam, N., Diaz, T., Mwamba, R., Setel, P., Mills, S. (2018). 'Civil registration and vital statistics in health systems'. *Bulletin of the World Health Organization* 2018:96	Contributing author in peer reviewed journal