Sharing is Caring: Intercultural Health Systems and Women's Participation in Global Health Policy

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Abstract

There is a general consensus in the academic and non-academic sphere that women should participate in health systems strengthening. Yet, implementable models that can facilitate this remain absent. Amidst attempts to open up International Relations (IR), intercultural health systems present compelling cases to examine what could impact women's agency in health policymaking. This contrasts with approaches centered on theoretical human rights rhetoric. This thesis analyzes how the Holistic Care Model, developed by the dr. Denis Mukwege- and Panzi Foundation, impacts women's participation in global health policymaking. An exploratory qualitative primary source analysis was conducted with postcolonial theory. The findings show that through developmental innovation and knowledge facilitation, the Holistic Care Model enhances the agency of women treated by it. The creation of agency has a multiplying effect: women actively tailor the model according to their health needs, which in turn makes them participants of the health system's development. The evidence also highlights health systems' relevance for postcolonial debates on international health governance. Though the research only analyzed one case, the findings provided an in-depth understanding of how a healthcare model can implement what theoretical formulations lack to execute. This makes the present singular case relevant for future innovations and shows that knowledge concerning health from the global South should be examined increasingly in IR and Women, Peace, and Security studies.

Key words: global health governance, health systems, gender, agency, policymaking, postcolonialism

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List of abbreviations

CRSV	Conflict-related sexual violence
DMF	dr. Denis Mukwege Foundation
DRC	The Democratic Republic of the Congo
ICHS(s)	Intercultural health system(s)
IR	International Relations
NGO(s)	Non-governmental organization(s)
OSC	One-Stop Centre
PF	Panzi Foundation
UN	United Nations
UNARMS	United Nations Archive and Records Management Section
UNDL	United Nations Digital Library
WHO	World Health Organization
WPS	Women, Peace, and Security

1. Introduction

January 27, 1997. Iqbal Riza, the Chief of Staff at the Executive Office of the Secretary-General, receives a note from M. S. Khmelnitsky, the Inter-Agency Affairs Officer of the World Health Organization (WHO). To meet changing global health issues, Khmelnitsky expresses the requirement of evolving health policies. He urges United Nations (UN) institutions to address the interdependencies between conflict, violence, health, and social development with innovative health policies.[1] Almost two decades later, the urgency to meet health needs concerning conflict-related violence against women is reiterated by the Nigerian doctor and Executive Officer of the UN Population Fund, Babatunde Osotimehin. He stresses how relevant women's participation in policymaking for implementation with real value is.[2]

Women's agency is considered imperative for health policymaking and health systems development. These sources show how innovative health systems and inclusive policymaking are in constant demand, yet not properly implemented. Human rights-based approaches to the health systems development are repeatedly contested, and there is a demand for health models sensitive to specific geopolitical and cultural contexts.[3] The UN promote intercultural health systems.[4] They present holistic approaches to healthcare and challenge Western health understanding.[5] An example is the Holistic Care Model, developed by the dr. Denis Mukwege and Panzi foundations in the Democratic Republic of the Congo (DRC). In the DRC, conflict-related sexual violence (CRSV) has persisted for more than two decades. The Holistic Care Model treats men and women who survive CRSV. Could it play a role for Khmelnitsky's and Osotimehin's demands? This thesis addresses the following question: How does the Holistic Care Model impact women's participation in global health policymaking?

By conducting a critical qualitative primary source analysis, this thesis argues that the Holistic Care Model impacts women's agency in health policymaking, particularly through driving development, knowledge production and exchange, and creating advocacy spaces. The model enhances agency by giving the women agency in their healing process, which leaves behind the passive victim role of women in health. While theoretical models are limited in their scope of impact, the Holistic Care Model implements what it urges others to do.

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[1] UN Secretary-General (1997-2006 : Kofi Annan), "Spec. Agencies 1997."
[2] UN Secretary-General (2007-2016 : Ban Ki-moon), "Women and Children's' Health," 2-3.
[3] Diowo Lunumbe, "Commentaire"; ADJMOR, "Informations"; Power and Allison, *Realizing Human Rights*.
[4] Asakitikpi, "African Indigenous Medicines," 367; UN Department of Economic and Social Affairs, "State of the World's Indigenous Peoples," 176–81.
[5] UN Department of Economic and Social Affairs, "State of the World's Indigenous Peoples"; Peprah et al., "Removing Barriers"; Kohli et al., "Congolese Community-Based Health Program"; Dahlberg, Todres, and Galvin, "Lifeworld-Led Healthcare."

I assess the questions by applying postcolonial theory. The material consists of archived UN documents and primary sources provided by the dr. Denis Mukwege and Panzi foundations. The literature complements the findings with state-of-the-art knowledge.

It may be assumed that an innovative, gender-specific health system that treats survivors of CRSV is evidently beneficial for women's individual and societal well-being. However, this paper suggests there is a difference between the evident advantages of the care model and the metaphysical value it may hold. This is especially relevant considering the geopolitical and historical context of the DRC and international human rights developments. How does the care model ontologically challenge the understanding of women's health in relation to their empowerment? Questions like these are not yet asked, and the analysis outcome is therefore not as clear as assumed.

Scholars have asked how women's agency in policymaking could be enhanced.[6] Nonetheless, research has insufficiently questioned how innovative health models from regional contexts influence this progress. This is critical to develop health systems while drawing attention to contributions from the global South and challenging universally applied Western medicine.[7] Tallberg highlights the need for more equal opportunities to participate in decision-making and development, while Harman says that health systems improvement is "neglected health"[8].[9]

This study contributes to established knowledge in several ways. It seeks to open up International Relations (IR) to more diverse stories and actors to investigate.[10] Furthermore, it draws attention to intercultural health systems' potential for women's empowerment. Thus, it connects two issue areas that have not received much academic attention yet.

This thesis is divided into two main parts. First, I conceptualize and historically contextualize key terms to establish an empirical foundation. This draws a clear picture of women in the DRC within that thematic context. After, a case study of the Holistic Care Model in the DRC is presented. Finally, this case is evaluated in terms of the model's application, production, and participation. This structure should establish a clear understanding of the intercultural health system's role in enhancing women's agency in health policies. To provide relevant answers to the respective debates, the next chapter reviews the academic literature.

[6] Laxminarayan and Dürr, "Engaging Survivors"; Power and Allison, *Realizing Human Rights*; Joachim, *Agenda Setting, the UN, and NGOs*; Gaventa, "Spaces for Change."
[7] UN Department of Economic and Social Affairs, "State of the World's Indigenous Peoples," 176; Harman, *Global Health Governance*, 12.
[8] Harman, *Global Health Governance*, 134.
[9] Tallberg et al., *The Opening Up of International Organizations*, 20.
[10] Thakur, "Africa and the Theoretical Peace in IR."

2. Literature review

Intercultural health systems (ICHSs) have not yet been explored sufficiently regarding women's participation in health policymaking. Scholars have provided an indispensable foundation for understanding participation dynamics and power shifts through civil society movements.[11] Global health scholars, on the other hand, have examined issues within their field concerning more traditional IR topics, such as power distribution.[12] A lack of focus remains on healthcare models that are not expected to be related to decision-making per se. No specific ICHS case has been tested as to what factors might impact women's participation in global health policymaking. A critical qualitative, historically informed, and interdisciplinary approach is needed to understand the intersection of ICHSs and power dynamics.

This chapter will bridge two relevant debates. First, it reviews the academic debate on participation in decision-making and power shifts. Secondly, contributions by global health scholars to the issue of historically rooted power inequities will be assessed. In so doing, it will be clarified why the presented research question is the logical next step in enhancing the discussion about healthcare models and health policymaking accessibility.

Concepts will be briefly defined. Different actors inherit different power levels. It enables them to perform certain actions, such as accessing certain leadership levels.[13] Other transnational actors are more attentive to their voices and experiences, giving them easier access to decision-making.[14] Power is a vital aspect of citizen agency.[15] The distribution of this power relates to global structural inequalities stemming from the historical roots of imperialism and colonization. Women are often deprived of active agency in global health through victimization.[16] In this research, empowerment and enhancing women's agency are seen as related to participation in decision-making. Accessing decision-making spaces involves historically entrenched power relations. Nonetheless, these relations are transformative.[17] Global health governance aims to eliminate health grievances and inequities. These inequalities are interlinked with colonial developments.[18] Global health policy is a part of global health governance and

[11] Gaventa, "Spaces for Change"; Spencer et al., "Solidifying or Splintering the Movement?"; Laxminarayan and Dürr, "Engaging Survivors"; Mathur, "Participatory Development"; VeneKlasen and Miller, *A New Weave of Power, People & Politics*; Batliwala, "Grassroots Movements as Transnational Actors."
[12] Mann et al., "Health and Human Rights"; Harman, *Global Health Governance*; Annas, "Human Rights and Health"; Amzat and Razum, *Globalization, Health and the Global South*.
[13] VeneKlasen and Miller, *A New Weave of Power, People & Politics*; Gaventa, "Spaces for Change."
[14] Gaventa, "Spaces for Change," 25.
[15] VeneKlasen and Miller, *A New Weave of Power, People & Politics*, 39.
[16] Laxminarayan and Dürr, "Engaging Survivors," 268.
[17] VeneKlasen and Miller, 39.
[18] Harman, *Global Health Governance*, 5.

entails multi-sectoral actors. It develops strategies to enhance people's health.[19] One of its most significant instruments is the generation of intelligence, which entails health systems development.[20] "Holistic" care means healthcare that considers a complementary approach to well-being. Depending on the disease, injury, and circumstances of a specific case, it targets more than one factor of human health as defined by the WHO: holistic care understands that for a person to fully heal, he or she must also be healthy mentally, socially, and economically.

The academic literature provides different answers to how civil society decision-making participation can be enhanced. Decision-making happens in several sectors, including health.[21] Gaventa points out how numerous factors must align for an individual or a community to prompt changes in different contexts. By examining power relations in this nuanced way, he considers the social and regional conditions of the respective actors.[22] Institutional efforts, for example by non-governmental organizations (NGOs), can only partly represent civil society if the people are not empowered, engaged, or simply physically and mentally capable of contributing to change. Hence, the creation of space for agency in specific settings is crucial for contributing to policymaking. Furthermore, it emphasizes the significance of healthcare systems and agency for innovative policymaking.

Research should look beyond conventional contexts of women's empowerment. Gaventa points to less obvious channels for accessing policymaking. This is strengthened by VeneKlasen and Miller; power is practiced and developed on multiple levels.[23] However, no light has been shed on ICHSs' role in this regard. Especially ICHSs, which connect care and empowerment,[24] seem to provide spaces for social development. Attention should be drawn to increasingly complex participation spaces, such as intercultural healthcare.

Methodologically and content-wise, the debate about empowering women needs to be opened up.[25] Mohanty underlines the importance of including a broad range of experiences while providing critical theory frameworks.[26] Evaluating a case of an ICHS such as the Holistic Care Model at the Panzi Hospital in the conflict-torn Eastern DRC through a postcolonial framework addresses this academic gap.

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[19] Barbazza and Tello, "A Review of Health Governance," 2; Harman, *Global Health Governance*, 4.
[20] Barbazza and Tello, "A Review of Health Governance," 6; Harman, *Global Health Governance*, 137.
[21] Weiss, Carayannis, and Jolly, "The 'Third' United Nations."
[22] Gaventa, "Spaces for Change," 30.
[23] VeneKlasen and Miller, *A New Weave of Power, People & Politics*, 47.
[24] UN Department of Economic and Social Affairs, "State of the World's Indigenous Peoples," 74.
[25] Batliwala, "Grassroots Movements as Transnational Actors," 398.
[26] Mohanty, "Under Western Eyes."

Nevertheless, I note the critique of inadequate research into "local" experiences in assessing social elevation.[27] Investigations of health systems development often include improper geographical and historical contextualization.[28] Hence, I stress including a historical perspective.

The connection between medical care and sociopolitical change is not new, but it requires more relevant historically informed case studies. Amrith examines public health during decolonization movements as well as institutional health governance within a postcolonial context.[29] He draws attention to the exchange of ideas along with changing power relations and global inequities with their roots in colonization. He also sheds light on the actors whose contributions to healthcare were forgotten or silenced.[30] This aligns with Asakitikpi's notion of Western healthcare systems being imposed on other societies without considering their historical, social, and cultural contexts.[31] The UN endeavor to overcome postcolonial healthcare structures, for example, by promoting a broader implementation of ICHSs.[32] Nevertheless, the academic landscape lacks qualitatively tested ICHSs case studies with applied postcolonial frameworks.

Health and societal change complement each other, and this has not been tested sufficiently with a focus on contributions from the global South. Amzat and Razum note that social developments impact global health.[33] How do the application, production, and participation in health policies, developed in the global South, influence social developments? More specifically, women's agency? Multidirectional examinations are needed to critically evaluate expertise from the global South. Thus, the connection between health systems and power relations is linked to the history of knowledge production. IR needs stories dealing with diverse emergences and implementations of such knowledge.[34]

While research lacks novel cases in this regard, gender-specific empowerment has been investigated. For NGOs focusing on women's health, it is highly beneficial to create the capacity to mobilize civil society actors.[35] The institutional empowerment of CRSV survivors can

[27] Mohan and Stokke, "Participatory Development and Empowerment."
[28] Dahlberg, Todres, and Galvin, "Lifeworld-Led Healthcare"; Peprah et al., "Removing Barriers"; Nolte, Merkur, and Anell, *Achieving Person-Centred Health Systems*.
[29] Amrith, *Decolonizing International Health*.
[30] Ibid., 9–15.
[31] Asakitikpi, "African Indigenous Medicines," 376; Amrith, *Decolonizing International Health*, 8.
[32] UN Department of Economic and Social Affairs, "State of the World's Indigenous Peoples."
[33] Amzat and Razum, *Globalization, Health and the Global South*, 10.
[34] Thakur, "Africa and the Theoretical Peace in IR"; Amrith, *Decolonizing International Health*, 186.
[35] Joachim, *Agenda Setting, the UN, and NGOs*, 11.

provide spaces for women to contribute to social movements.[36] Nonetheless, their approach looks at a stage beyond diseases inflicted upon women caused by CRSV; care and healing is not the variable in question. However, including medical approaches is essential. Such an approach can generate new findings: first, it can propose innovative care models that set women's agency at the center of their healing process after horrific abuse and trauma, thereby surpassing limited theoretical models. A second benefit is the contribution it makes to Women, Peace, and Security (WPS) studies and global health governance and -studies.

ICHSs are a global governance subject and need more differentiated investigation. Global health is directly connected to more traditional IR topics, such as security and peacekeeping.[37] Despite the valuable findings on the interconnectedness of health, global governance, human rights, and global inequities, a thorough inclusion of ICHSs has so far been absent from this debate.[38] Vaughan stresses the importance of interdisciplinary approaches to sociopolitical topics and advocates for expansionary conceptualizations.[39] ICHSs should also be investigated through various case studies. Needless to say, an understanding of their role in accessing policy-making spaces is missing, too. This means that the research so far remains incomplete.

Concluding, the research question identifies the need for a more comprehensive examination of the interrelationship between women in global health policymaking, ICHSs, and global inequities. It points to an unresolved problem and thus contributes to the research environment. Scholars have provided valuable answers concerning civil society empowerment and global health inequities. However, too little is known about how the debates complement each other, how ICHSs play a role in this context, and how it affects women in health. The research is necessary to develop a more complete picture of health systems and empowerment. These interdisciplinary questions require theoretical nuance. The next chapter on the research design will demonstrate that this is only possible through conducting case studies with qualitative primary source analysis.

[36] Laxminarayan and Dürr, "Engaging Survivors."
[37] Harman, *Global Health Governance*, 1; Annas, "Human Rights and Health," 1778.
[38] Harman, *Global Health Governance*; Amrith, *Decolonizing International Health*; Fried and Gaydos, *World Health Systems*.
[39] Vaughan, "Conceptualising Metabolic Disorder in Southern Africa."

3. Research design

As the literature review has shown, there is a need for an innovative approach to women's access to decision-making spaces and the assessment of ICHSs. This chapter critically presents the research design.

3.1. Case selection

The Holistic Care Model (HCM) is a compelling case of an ICHS developed in the specific geopolitical context of conflict in the DRC.[40] It originated and is executed at the Panzi Hospital in the DRC. This implies a significant foundation for testing an ICHS in a specific context but also for testing the chances of women's empowerment in that context. The model moves beyond the traditional fragmentation of healthcare that focuses *either* on physical, psychological, *or* socioeconomic well-being. Yet, it includes elements of this Western-coined medical approach and, therefore, creates a special kind of holistic care. It pays special attention to the sociocultural circumstances in the region.[41]

The advantages of this case are manifold. While the analysis of only one case might carry, at first sight, only little representative value, it allows for a focused and rigorous analysis of one healthcare model. The case is an opportunity to tell decentralized stories. Thakur stresses this aspect, stating that Africa's knowledge production is a crucial aspect in the academic sphere of IR as well as in the Global North generally.[42]

There is a consciousness of the case's sensitivity and ethical responsibility. The aim is *not* to portray the victims and survivors who are treated at the Panzi Hospital in a certain way. Neither do I act representative of these men and women. Moreover, the thesis does not aim to impose a certain role on the HCM participants, neither patients nor staff. Instead, the aim is to test how a healthcare model's constituents might impact women's participation in health policymaking.

Why were the DRC and CRSV-related health issues chosen to address the research question? The HCM is an innovative health model that emerged from a conflict-stricken region that experiences a high rate of violence against women. The emergence of novel approaches to healthcare under the most adverse conditions makes their implementation and effectiveness relevant, especially for local women's empowerment. Though men are also treated at the Panzi

[40] Mukwege, "Rape as a Weapon of War"; Mukwege, Mohamed-Ahmed, and Fitchett, "Rape as a Strategy of War"; Mukwege and Berg, "The Panzi Hospital One-Stop Centre Model of Care."
[41] PF, DMF, and Hôpital GR De Panzi, "Handbook," 10–13; Mukwege and Berg, "The Panzi Hospital One-Stop Centre Model of Care."
[42] Thakur, "Africa and the Theoretical Peace in IR," 225.

Hospital, this paper focuses on girls and women, as they are comparatively higher exposed to CRSV and related diseases.[43]

The Panzi Hospital is connected to the Panzi Foundation (PF) and the dr. Denis Mukwege Foundation (DMF), its sister foundation in The Hague. This allows for a partial reduction of the physical distance to the case and solid access to useful primary sources. Therefore, the geographical scope of the case stretches beyond the DRC and includes work done in The Hague. Nevertheless, a geographical and metaphysical distance remains; the awareness of this will be incorporated into the research.

This research concentrates on the understanding of healthcare, not on international institutions. The pharmaceutical industry is a central component of global health governance. However, the focus here lies not on the industry but on the development of a more holistic understanding of health systems and their role for women. As the following chapters will show, this is crucial for women's participation in health policymaking. This makes developers, beneficiaries, and survivors the main actors.

The case spans 1989 until 2019. It incorporates the antecedents of the First Congo War. It is imperative to consider this for four reasons: firstly, it determined the rising incidence of CRSV in the region, which prompted, secondly, Dr. Mukwege ten years later to shift his focus on the treatment of CRSV survivors.[44] Thirdly, the historical and geopolitical context of the case must be involved. Finally, this marks a period of significant developments in human rights formulations within the UN. This is relevant as the contemporary human rights rhetoric plays a significant role in conflicts and preserving (health and gender) security.

3.2. Methodology and theoretical framework

The case will be assessed through an exploratory qualitative primary source analysis. This allows for an in-depth analysis of the HCM and its connection to relevant UN formulations. Furthermore, this method suits the scope of this thesis and the choice of examining only one case. Finally, it allows for the exploratory application of combined debates and two main primary sources corpora. The method provides an adequate framework to balance primary and secondary sources.

Postcolonial theory does justice to the case's intersectional and historically and culturally sensitive background. Positivist approaches to this case would be insufficient. Historiography that looks beyond the narrative of neoliberal competition between the North and South

[43] PF, DMF, and Hôpital GR De Panzi, "Handbook," 9.
[44] Ibid., 4.

for modernization can be found particularly in postcolonial theory.[45] Examining knowledge and innovations in healthcare from the DRC needs a theoretical framework that jolts Eurocentric narratives and achieves to involve colonial pasts.[46] Moreover, it matches the research question's connection to overarching questions concerning shifting historically established power relations. Thus, postcolonial theory gives room for investigating the health model in connection to decolonizing global health governance in a gender-considerate way.

3.3. Primary source selection

The data selection concentrates on two main bodies of material: on the one hand, the DMF and its sister foundation Panzi and, on the other hand, the United Nations Archive and Records Management Section (UNARMS) and the United Nations Digital Library (UNDL).

The DMF and the PF provide sources such as handbooks, reports, websites, and scientific evaluations written by medical practitioners, scholars, and the foundations' staff. These documents are relevant as they provide first-hand insight into the HCM's functioning. However, the sources were generated by the foundations and will therefore be evaluated from their perspective. Sources may be affected as foundations depend on funding. The sources originated at various times within the chosen time frame. They will mainly be assessed online or through communication with the DMF.

The UNARMS and the UNDL provide relevant declarations, drafts, resolutions, formal and informal papers, and letters from UN staff. These sources provide a backbone for examining ICHSs. The UN is linked to their development. Therefore, they present historiographical documentation of social issues. This complementary source selection provides a conceptual foundation for the case study.

4. Historical contextualization and conceptualization

4.1. Participation and decision-making in the DRC

The previous chapters highlighted the interrelation between health systems strengthening in the global South and women's participation in health policymaking. However, in what context is the research embedded? What insights can the UN's women's rights developments provide? This chapter will draw a clearer picture of the case's historical and regional context.

[45] Krishna, *Globalization and Postcolonialism*, 156.
[46] Dunne, Kurki, and Smith, *International Relations Theories*, 220–23; Thakur, "Africa and the Theoretical Peace in IR," 213.

The DRC's past and present conflicts have been continuously impacted by the West's (post-)colonial controversial interests in the country's resources. In political terms, Kisangani argues that the DRC's history started in 1885 with the Berlin Conference.[47] After independence in 1960, the relationship with former colonizers and remaining stakeholders of natural resources, such as France, Belgium, and the United States, remained a continuing aspect of the DRC's complex history.[48] This relationship bore tensions for the DRC internationally and domestically: in the late 1990s, during the civil war against President Kabila, foreign funding and Western demand for natural resources lead to an intensification of domestic economy and politics and, paradoxically, isolation of foreign relations.[49] Hence, the West and its heritage from colonial times played a central role in the controversial character of the DRC conflicts before 1989 and after.[50]

Mobutu's and, after his emigration into exile in 1997, Kabila's handling of international economic and political issues translated into further domestic tension. This affected especially the opportunities of Eastern Congolese civil society to have their voices heard. After almost 30 years of corrupt dictatorship, it had become difficult to challenge the power monopolies of national ministries.[51] The decrease in socioeconomic productivity additionally impacted the municipal institutions' internal structures and governmental and communal management.[52] Hence, the executive, legislative, and judiciary levels were impaired. Consequently, fair trials, protection, and local citizen participation in decision-making lacked opportunity and consistency. Ndyanabo et al. and Chamaa and Ndagiriyehe underline the anarchic structures in Bukavu.[53] It was in this conflict-struck period with domestic structural difficulties that Dr. Mukwege opened the Panzi Hospital in 1999.[54]

Nevertheless, other sectors such as education grew significantly, and coherent reforms were introduced.[55] The aggrieved conditions did not make civilians in Eastern Congo more passive or less informed; women are even increasingly educated about their rights in conflict.[56]

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[47] Kisangani, *Civil Wars, 1960-2010*, 11.
[48] Kisangani, *Civil Wars, 1960-2010*; O'Malley, "'What an Awful Body the UN Have Become!!'"
[49] Kisangani and Bobb, *Historical Dictionary,* lxxvi; 473.
[50] Kisangani, *Civil Wars, 1960-2010*, 5–6; 32.
[51] Mohan and Stokke, "Participatory Development and Empowerment," 250.
[52] Njangala, Thill, and Musamba, "Reform in Bukavu," 2.
[53] Ndyanabo et al., "Développement de la ville de Bukavu," 126; Chamaa and Ndagiriyehe, "Evolution et structure de la population de Bukavu," 44.
[54] Mukwege and Berg, "The Panzi Hospital One-Stop Centre Model of Care," 2; *Nobel Peace Prize Lecture*, 1:00-1:17.
[55] Bugandwa Mungu Akonkwa, Kanyurhi, and Bakomeza Byavulwa, "La Ville de Bukavu"; Malu and Walingene, "Teacher Training."
[56] *I am a Woman from the DRC,* 0:53-1:00.

How can this paradox be explained? While it can be assumed that multiple factors play a role here, the following subchapter explores human rights developments for women's health in the given context.

4.2. Women's rights and health

Parallel to unlikely circumstances in the DRC for women to enhance their agency, the end of the Cold War opened up a wider range and depth of possibilities for human rights developments.[57] In the late 1980s and early 1990s, scholars and policymakers showed a growing concern to women's rights.[58] However, how should women's health be conceptualized?

The early 1990s human rights rhetoric conceptualized women's well-being as rather passive and demographically relevant. The Declaration on the Elimination of Violence against Women in 1994 marked one of the first UN resolutions concerning women's rights after the Cold War had ended. Granting women the right to health as defined by the WHO was central.[59] Interestingly, the agenda did not necessarily prioritize health for women's self-determination and agency. It is argued that women's health at the UN concentrated particularly on reproductive rights; it was connected to demography.[60] Therefore, while the idea and purpose of the UN's formulations appear clear and incontestable, they are more complex concerning their final destination: women were conceptualized in a rather passive way.

Protecting women's well-being and inclusion is too commonly uncritically viewed as an overarching theoretical goal. This results in an absence of nuance and creativity as to how this can be implemented. This is supported by a plan signed by Namibian politician Martin Andjaba and a conference hosted by Namibia in 2000. It problematizes the continuing absence of proper implementation plans and ontological depth when challenging violence against women and their health. He proposed a multilateral, holistic, gender-specific perspective and practical implementation mechanisms.[61] This also points to a more constructivist perspective on women's health: rather than industries such as big pharma, new implementable ideas are relevant. The broad rhetorical appreciation of protecting women's well-being does not suffice for protection and security in conflict regions. Different ontological approaches serving a more suitable and sustainable implementation are needed. Coherently, to meet Osotimehin's demand

[57] Corrêa, Germain, and Petchesky, "Thinking beyond ICPD+10," 110.
[58] Ibid., 111–12.
[59] UN General Assembly, "Declaration on the Elimination of Violence against Women," Art. 4 (g); Art. 3 (f).
[60] Joachim, *Agenda Setting, the UN, and NGOs*, 1.
[61] UN General Assembly and UN Security Councila, "Letter from the Permanent Representative of Namibia."

for women's participation, such a model must overcome the passive victim narrative of women that denies them their agency.[62]

Between 1989 and 2019, there is a shift in the interpretation of women's rights and health. In the Rome Statute of the International Criminal Court from 1998, it becomes clear that women's health is elevated to issues beyond the body and reproduction, namely to international security. There is a clear accentuation of gender, health, and CRSV among the Articles dealing with war crimes and crimes against humanity.[63]

A year later, the Economic and Social Council further developed the concept of women's well-being with a more holistic perspective. It linked women's health to participation in decision-making. It acknowledged the following:

> "[…] the link between women's physical and mental health throughout the life cycle and the level of national development, including […] women's status and degree of empowerment in society [and] the importance in women's health for the well-being of *women themselves and for the development of society as a whole*."[64]

This quote from 1999 considers the connection between *individual* women's well-being and their participation in *communal* well-being. Thus, it values female well-being for their active participation in shaping, not merely producing, a society. There is a clear development of the rhetorical conceptualization concerning women's health.

Yet, considering the contemporary circumstances in Eastern DRC, this rhetorical appreciation is difficult to translate into conflict regions. Therefore, elevating women's health and their participation in policymaking needs multilateral approaches with new actors, ideas, and methods. The UN established platforms for multilateral, decentralized exchange.[65] Nevertheless, the organization is not immune to internal and external contradictions when *implementing* the rights that it establishes. Global discrepancies between the global South and North in voting illustrate this at the very least.[66] How can the rights, well-being, and agency of women from different cultural and geopolitical contexts be enhanced?

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[62] Laxminarayan and Dürr, "Engaging Survivors," 268.
[63] UN Diplomatic Conference of Plenipotentiaries on the Establishment of an International Criminal Court, "Rome Statute of the International Criminal Court."
[64] UN Economic and Social Council, "Commission on the Status of Women," I. 5, author's accentuation.
[65] Papuc, "UNHCR and Non-Governmental Organizations," 518; UN International Computing Centre, "UN Partner Portal."
[66] UN General Assembly, "General Assembly Official Records, Sixty-fourth Session. 65th Plenary Meeting."

4.3. Intercultural health systems

4.3.1. Definition

The connection between woman's health and agency in developing societies is given, and ICHSs can play a role here. Health systems involve different interconnected stages of planning and management to improve individuals' health.[67] For this thesis, the strategies, governance, innovation, and understanding of health are particularly relevant. Health systems have diverse histories. Ancient African traditional health systems were impaired and suppressed by colonialism and the establishment of a narrative of superior Western, evidence-based medicine.[68]

ICHSs account for ontological and methodological pluralism within those stages and levels of planning, management, and practice. They do not always replace but can complement universally applied Western-coined medicine.[69] This implies compound forms of medical care.[70] Hence, ICHSs challenge power relations established through a hierarchy in knowledge production within health policy.

It is tempting to assume that ICHSs have one invariable definition: one that highlights the value of methods, practices, and natural means (such as herbalist approaches) of indigenous medicine coexisting, as an alternative, to Western medicine.[71] However, their application in specific local scenarios reveal their complexity. ICHSs do not just imply parallel competitiveness. Western and traditional healthcare characteristics can be intertwined diversely. Due to ongoing developments of ICHSs in different contexts, the term continues to be challenged.[72] The critical component of ICHSs are local minority groups trying to increase the recognition of their identity and struggles in a globalizing world.[73] Hence, ICHSs need to be conceptually opened up.

In light of Vaughan's call for an expanded conceptualization of global health issues,[74] I argue that ICHSs' definition should not only include the parallel choice between healthcare cultures. Instead, ICHSs can be nuanced models that fuse different understandings of healthcare to varying degrees. This includes targeting various factors of human health, such as

[67] Martin, *Health Systems*.
[68] Asakitikpi, "African Indigenous Medicines."
[69] UN Department of Economic and Social Affairs, "State of the World's Indigenous Peoples," 176–77.
[70] Torri, "Intercultural Health Practices," 31.
[71] Torri, 32; Asakitikpi, "African Indigenous Medicines."
[72] Torri, "Intercultural Health Practices," 42.
[73] Ibid., 32.
[74] Vaughan, "Conceptualising Metabolic Disorder in Southern Africa."

psychological or social. Therefore, ICHSs can be forms of holistic care. Nonetheless, their inherent complexities bear limitations.

4.3.2. Limitations

An ICHS can imply competition and include conflicts between diverse actors, who may disagree on the health system. Relevant institutions can refuse implementation procedures.[75] Furthermore, there may be no consensus as to how legitimate the project is and who bears the responsibilities.[76] Hence, ICHSs include a difficult alignment of variables. These variables may relate to structural power discrepancies. Before such underlying problems can be overcome, it remains complicated to promote ICHSs locally and globally.[77]

Limitations remain even if all parties align and if roles are clearly defined. The implementation may require extensive financing and administration.[78] Even if monetary and human resources are available, hospitals and foundations depend on funding. This can limit their efficacy and legitimacy.

4.3.3. Potentials

Nevertheless, ICHSs hold manifold potentials, which can be summarized in three overarching categories: (i) development, (ii) agency, and (iii) knowledge production.

Firstly, ICHSs hold developmentary potential for healthcare and social programs. They are complementary in nature and provide novel modes of care.[79] Additionally, these evolving forms tend to originate in the respective circumstances people live in and experience disease. This promises well-suited implementation and serves health more holistically than decentralized established health systems.[80] This presents a more fruitful foundation for other developmental programs.

Secondly, ICHSs can create space for agency for those contributing to and developing the system and for those treated by it. Health and treatment become entities of participation and self-determination;[81] this makes ICHSs noteworthy spaces to investigate participation.

Finally, ICHSs can be important for knowledge production and expertise. It can originate from the actors involved in the working processes. Moreover, health is determined by

[75] Torri, "Intercultural Health Practices."
[76] Harman, *Global Health Governance*, 1.
[77] Torri, "Intercultural Health Practices," 43.
[78] Ibid., 40–46.
[79] Ibid., 38.
[80] Ibid., 38.
[81] Ibid., 44.

processes of globalization, which makes the creation of knowledge in the context of ICHSs relevant for transformative global health issues.[82] Therefore, ICHSs can be a factory of global contributions to pluralist knowledge production.[83]

Despite a vulnerability to competition, ICHSs can counteract hegemonic social and medical structures by linking the potentials in development, agency, and knowledge production. But do ICHS cases fulfill this potential? If yes, how? What aspects make them relevant for women in policymaking? This will be investigated by examining the HCM in the following chapter.

5. Analysis

The last chapter conceptualized and historically contextualized the DRC, women's rights, and ICHSs. Now, one can look at the South-Kivu region in Eastern DRC and examine women's situations and health approaches. The HCM will be presented. Finally, the model will be critically examined.

5.1. Women in South Kivu and healthcare

The importance of examining specifically women and health approaches in the region of the Panzi Hospital stems from the premise that women should not be viewed as a homogeneous group. Women's well-being is continuously affected by the ongoing conflict in the DRC.[84] It is, however, imperative to emphasize that women are not just comprised of the fact that they are women in conflict regions. Cultural, institutional, socioeconomic, and other intersectional factors count.[85] This is why this thesis first looked at the DRC and global dynamics, and now the analysis will zoom into more local circumstances and investigate the HCM accordingly. Global and local dynamics should be considered, as they both impact a woman's life.[86] As the following analysis will show, this is one part of the HCM's approach.

CRSV can sustainably damage a survivor's well-being.[87] The chance of him or her fully healing is often low, as an assault is not just catastrophic to the physical and mental health; concerning CRSV, there is a limited application of justice and socioeconomic protection in

[82] Amzat and Razum, *Globalization, Health and the Global South*, 10.
[83] Thakur, "Africa and the Theoretical Peace in IR," 225.
[84] DMF, "Annual Report 2019"; Fondation du Grand-Duc et de la Grande-Duchesse, "Stand Speak Rise Up," 79.
[85] Mohanty, "Under Western Eyes," 72.
[86] Medie and Kang, "Power, Knowledge and the Politics of Gender in the Global South," 38.
[87] DMF, "Annual Report 2019," 7.

South Kivu.[88] Stigma and social exclusion can follow the attack, partly due to lacking institutional backup. Rejection by their partners and families often leaves women without social and economic support.[89] Regular hospitals may provide physical therapy; such settings, however, can expose survivors to a discriminating environment. Moreover, many women do not seek physical health supervision due to travel logistics or emotional distress and trauma.[90] Hence, there is drastic individual suffrage during and after the crime on a physical and emotional level, but stigma and lacking judicial and legislative infrastructure makes it almost impossible for survivors to properly rebuild their lives. Their "physical, mental and social well-being"[91] is heavily impeded.

International organizations address this problem with theoretical appeals. The Security Council resolution 2106 of 2013 emphasizes CRSV and women's empowerment in the social and economic spheres. If one focuses on the actors involved in these considerations, it is surprising that next to UN staff, Member states, parties involved in the conflict, humanitarian sectors, and international human rights lawyers, no medical actors are involved.[92] This implies a gap in the policy. The resolution states the urgent need for:

> "[…] health services, including sexual and reproductive health, psychological, legal, and livelihood support and other multisectoral services for survivors."[93]

As the next chapter will show, ICHSs can cover these needs while simultaneously making women of the global South active participants in this development.

5.2. The Holistic Care Model

Women's needs in South Kivu are not sufficiently met by conventional hospitals, health systems, local institutions, and UN resolutions. Although the latter is imperative for development in this matter, a locally and culturally contextualized implementation of human rights values remains difficult.

The DMF's HCM considers the individual circumstances of survivors. It offers four types of care: physical, mental, judicial, and economic. This care is aligned with the individual

[88] DMF, "Annual Report 2019," 14.
[89] PF, DMF, and Hôpital GR De Panzi, "Handbook," 11.
[90] Ibid., 12.
[91] WHO, "Constitution of the World Health Organization," 1.
[92] UN Security Council, "Resolution 2106 (2013)."
[93] Ibid., 5.

circumstances a survivor finds herself in.[94] This is critical considering the above-mentioned lack of context-specificity within UN formulations, conventional hospitals, and academia.[95]

A balance between scientific screening and humanitarian values forms the system's foundation. Beneath the four pillars lies the core practice of "Evidence-Based Programming" alongside "Compassionate Care".[96] The HCM is an example of how healthcare itself, the four pillars, are only one part of a comprehensive structure that connects compassionate care, screening, and empowerment of survivors. The whole system depends on a balance between monitoring and compassionate, context- and gender-specific approaches.[97] The model is at the nexus of health systems development and civil society agency.

The HCM's holistic understanding of women's well-being incorporates women as active agents of their well-being. According to the foundation, it is a tool to treat and help women overcome injustice. Reading between the lines, however, shows there is another level to it. The HCM presents a fundamentally different understanding and practice of women's health. It links individual and communal well-being as proposed by the Economic and Social Council in 1999. It combines a "person-centred"[98] approach with an appreciation of female empowerment for their well-being and a flourishing society. Hence, while aligning with UN formulations in considering the collective and security value of a woman's well-being, it elevates the role of the individual in her care.

The mechanism is perfectly suited to Bukavu's sociocultural and geographical surroundings and the survivors' condition. The HCM consists of the "One-Stop Centre"[99] (OSC). This means care seekers can receive fourfold aid at one location – Panzi Hospital. Women do not have to travel to several facilities. Therefore, they do not have to risk extensive travel or further harassment and stigma in regular medical settings. For remote residents, there is a mobile care service.[100]

Each pillar of care is equally essential for an individual's well-being.[101] Conventional health systems prioritize physical care. Though physical emergencies are treated first, the DMF stresses that some survivors are emotionally not ready to undergo physical treatment.[102] Therefore, the HCM as an ICHS can provide holistic care without generically prioritizing one practice

[94] Mukwege and Berg, "The Panzi Hospital One-Stop Centre Model of Care," 2.
[95] Mohanty, "Under Western Eyes."
[96] PF, DMF, and Hôpital GR De Panzi, "Handbook," 12.
[97] Ibid.
[98] Mukwege and Berg, "The Panzi Hospital One-Stop Centre Model of Care," 2.
[99] Ibid.
[100] PF, DMF, and Hôpital GR De Panzi, "Handbook," 22.
[101] Ibid., 11.
[102] Ibid., 10.

over another. The HCM is an ICHS as defined in the conceptualization section: conventional treatments are incorporated into a more holistic scheme that values the survivor's social, cultural, and geographical surroundings and needs. Socioeconomic and legal matters are not used to support healing but are considered part of healing.

The HCM outperforms theoretical appeals by linking women's healing to their agency from the beginning. Whether they receive care from all four pillars, partially, or only one, is their choice. This also makes them active participants in continuously developing the model in practice; it is a multiplying effect no theoretical model could achieve. By giving women the chance to be active agents in their healing process, health systems development takes place on the ground by the women. Moreover, they get the opportunity to advocate through various channels of the foundations' global network. This includes the Global Network of Victims and Survivors to End Wartime Sexual Violence/SEMA movement, which provides survivors a platform to speak up about CRSV and their experiences.[103] When the HCM is implemented, it empowers women sustainably – it practices what it urges other theoretical models to do.

Empowerment starts even before the process of healing begins; it begins with the staff. While the foundations acknowledge the importance of individuals such as Dr. Mukwege, they promote a health system where everyone involved is educated and trained to actively contribute and promote shared values. Hence, I want to emphasize again that the HCM transcends treatment. Cooperation between medical practitioners, lawyers, and civil society initiatives makes the model additionally relevant for new channels of empowerment.[104] Therefore, the HCM's application is relevant for women's empowerment even before a woman enters the OSC.

Overall, this system provides women with a strong base to become healthy and involved in the process. This falls in line with Gaventa's argument that bottom-up change requires numerous factors, including individual health-related aspects, to align with the sociocultural context.[105] The HCM, its OSC, and its four pillars are contributing crucially to women's structural (re)integration and their participation in health systems development.

But how does the HCM fulfill the ICHS potential? Does it also have limitations? The following chapter will investigate the health system in-depth and test its application, production, and participation critically.

[103] PF, DMF, and Hôpital GR De Panzi, "Handbook," 12.
[104] Ibid., 14-15.
[105] Gaventa, "Spaces for Change," 30.

5.3. The Holistic Care Model's application, production, and participation

The previous chapter showed how the constituents of the HCM create favorable conditions for women in South Kivu to be empowered. But how does the HCM impact women's participation exactly? Does the HCM fulfill the potentials of an ICHS or is it limited in its socially elevating scope?

Application

The HCM holds a rich structural foundation for social change and agency. As clarified above, power can be attained and established, but to a certain degree, it also needs response from other powerful actors. Is the HCM, next to an exceptional provision of care, only an inimitable message or is it applicable elsewhere?

What is needed for non-state actors to change existing power structures? Fouksman highlights the importance of institutions concerning development as "global epistemic bridges"[106]. One could argue, then, that the sheer existence and output of the foundations' network and their HCM are significant for transporting a movement of CRSV survivors to policymaking.

However, the HCM is constructed to be applied in diverse institutional and geographical contexts. Two kinds of institutions are significant for the foundations and for examining women's participation in health policymaking: state and non-state actors with international agency and local as well as global health institutions such as hospitals or intelligence bodies. Chapter 5.2. has shown that the care provided in Bukavu addresses the individual well-being and agency, healthcare systems, and society.[107] Moreover, it is reminded that the *handbook* is meant for other actors to utilize it and inform themselves as to how the HCM can be applied elsewhere. Hence, the application of this model in various contexts is considered. This is not only a possibility but requirement for sustainable and systematic health systems strengthening and social change.[108] Furthermore, the significance of this applicability for sustainable change was stressed, among others, at the World Health Summit High Level Event in 2020. German medical practitioner and scientific journalist Dr. Eckart von Hirschhausen underlined George Marshall's notion of changing existing multilateral institutions rather than creating new ones.[109] Women's participation in this process, as demonstrated by the HCM, could present a case Khmelnitsky and Osotimehin asked for.

[106] Fouksman, "Civil Society Knowledge Networks," 1865.
[107] PF, DMF, and Hôpital GR De Panzi, "Handbook," 27–29.
[108] Mukwege and Berg, "The Panzi Hospital One-Stop Centre Model of Care," 5-8.
[109] "Developing Strategies for Fighting COVID-19 around the World," 4.

The presented model works in other regional contexts. The technical possibility to integrate the HCM into established health systems presents an increasingly effective way of health systems strengthening and practically developing women's rights beyond the DRC's borders.[110] But does it work? A successful example of this implementation in a foreign health system is the case of Bangui in the Central African Republic.[111] This applicability of the HCM in other contexts is significant as the self-substantiating effect of women actively engaged in their healing and systems development is carried to other global contexts. Moreover, it presents a case where bureaucratized health systems open up. The application and bureaucratic change make space for transnational actors to advocate for women's agency, as is the case with the foundations and their activists.[112]

Thus, next to treating women holistically and enhancing their agency in doing so, the transference of holistic care to meso- and macro-perspectives must be highlighted.[113] It promotes health systems strengthening and global institutional change through the integration of the HCM in preexistent healthcare patterns.[114] Additionally, this ICHS involves a highly gender-considerate ontology, which makes the spread of the healthcare model relevant to women's empowerment and inclusive global health policymaking.

This applicability and the mechanisms provided by the foundations up until 2019 can tackle challenges the international community has been facing for at least twenty years. In a private letter from 1998, UN Secretary-General Kofi A. Annan shares his concerns about the efficiency and legitimacy of the UN with his advisor Bo Ekman. Ekman mentions how other mechanisms and interfaces between actors may be "faster and more efficient"[115]. Could the HCM be considered such a more efficient mechanism that takes off where the UN institutions and human rights rhetoric fail to implement a needed gender-transformative, holistic care, and rights protection?

This is arguable as the HCM provides application mechanisms that are proven to work, are context-sensitive, and include female agents as central components. Facilitating the implementation of a model that empowers women in their specific circumstances is beneficial for women's participation in the DRC and internationally. Through a health approach, context-specificity is provided where human rights rhetoric and academia still lack respective

[110] PF, DMF, and Hôpital GR De Panzi, "Handbook," 29.
[111] DMF, "Holistic Care for Survivors Worldwide."
[112] Joachim, *Agenda Setting, the UN, and NGOs*, 170; 178.
[113] Mukwege and Berg, "The Panzi Hospital One-Stop Centre of Care," 5.
[114] Álvez-Marín et al., "Legal Personhood of Latin American Rivers," 149; Harman, *Global Health Governance*, 8.
[115] UN Secretary-General (1997-2006 : Kofi Annan), "V.I.P E 1998," 1-7.

sensitivity. The foundations nurture established health systems and the implementation of women's rights. This is clarified by the following quote:

> "[The collaboration between the foundations and the Panzi Hospital] promotes existing health services, national and international judicial mechanisms, and the rights of women and girls."[116]

Comparing this note in the handbook with the earlier-mentioned statement by the UN Security Council from 2013 reveals a striking congruence. It reiterates the need for the following services:

> "[…] health services, including sexual and reproductive health, psychological, legal, and livelihood support and other multisectoral services for survivors."[117]

Considering the developmental potential of ICHSs from the conceptualization section, the HCM can be considered a successful example. It works and is congruent with what the Security Council found lacking in 2013. Moreover, it provides tailored care applicable to specific sociocultural and geopolitical contexts, which promotes women in their circumstances to contribute to the care accordingly. The model's development by women in a conflict region makes it even more relevant and resilient to changing geopolitical circumstances elsewhere. This is strengthened by Kohli, who stresses the requirement of an increase in health services tailored to local circumstances.[118]

It is reminded that this conclusion is based on the findings from the foundations' sources. Studies including interviews or sources from third parties, for example, would provide a different angle. Nevertheless, the premises of the foundations and coherent actions up to 2019 seem to fulfill the potential of an ICHS as proposed in Chapter 4.

If healthcare and the alignment of women's rights must be so context-specific, how can the application elsewhere not be generalized? In other words, how can a healthcare model be universally applied without being generic toward the survivors? Does the model, despite its flexible applicability, not also face limitations in its production? Does it clash with other modes of knowledge on health systems? These questions will be examined in the following section.

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[116] PF, DMF, and Hôpital GR De Panzi, "Handbook," 13.
[117] UN Security Council, "Resolution 2106 (2013)," 5.
[118] Kohli et al., "Congolese Community-Based Health Program," 8.

Production

With respect to the research question, the HCM's crucial output for women in policy-making can be mainly characterized by two aspects: development and knowledge production.

Development

In the conceptualization section, it was established that ICHSs hold developmental potential. Findings of the previous chapter suggest that the HCM can be considered as fulfilling this potential due to its origination in a conflict region. It can be applied and tailored in other contexts with other individuals' needs. However, limitations of ICHSs must be considered: though the application can be context-specific, the overall context of the application may not be well-suited or "welcoming". The letter exchange between Annan and Ekman suggests the notion of comparison or even competition between different developmental and humanitarian policies and models. The DMF states that the HCM is exceptional compared to conventional humanitarian development programs.[119] Could institutional or knowledge systems competition jeopardize the development of women's agency in policymaking through ICHSs?

Drawing on Ekman's remarks from 1998, I suggest that non-state actors such as the DMF and PF are not necessarily more efficient than the UN, but complementary to its ambitions. While UN human rights formulations define *what* needs to be developed or changed, the HCM is one example of *how* this can be achieved. Concerning its production, the HCM entails a paradox: on the one hand, it can be tailored, hence universally applied. On the other hand, there is no generalization taking place that promotes "cultural reductionism"[120]. The HCM makes this also practically impossible as it is the women who define the HCM's local application. My argument of practical complementation is further supported by the representation of DMF members and survivors at the UN Commission on the Status of Women. Here, an event specifically for the HCM was held.[121] It stresses the inclusion of medical developmental programs aimed at social empowerment. This slightly defies the note of competition.

The expansion of the model's production implies decentralized agency. Global training and meetings combine approaches to implement the HCM in partnership. An example is the 2019 International Conference on the Great Lakes Region (ICGLR) and the Regional Training

[119] DMF, "Holistic Care."
[120] Mohanty, "Under Western Eyes," 74.
[121] DMF, "Annual Report 2019," 20.

Facility (RTF).[122] Survivors are most often included and asked to play a primary role, report on results, share knowledge, and discuss the possible repetition of best practices. Hence, the production of the HCM goes beyond supplying care for CRSV survivors: it makes women agents of development also *after* their healing at the OSC. Action is taken to other contexts of health policy, and its output is critically discussed by survivors who actively develop the model and become agents of the global South.

This points toward another argument that underlines the HCM's potential to serve women's empowerment and to jolt global power relations: knowledge production and exchange of expertise.

Knowledge production and expertise

The previous subchapter showed that the HCM provides space for women to engage in the production of health systems development that is flexible to their local circumstances and needs. Consequently, it contributes to local and global development efforts. This is inherently connected to the foundations' premise to share the knowledge produced in the DRC and other locations the HCM has been applied in.

Knowledge facilitation matters for women's access to health policy and local and global power relations. The expertise accumulated in the medical field and its circulation are significant for social and political spheres.[123] Scholars of medical history have established the link between, on the one hand, knowledge production and exchange, and, on the other hand, scientific and political power positions. Cooperation and division between colonizing and colonized practitioners and political figures could influence or hinder scientific progress.[124] However, this is true for the postcolonial context as well: health diplomacy is central for South-South cooperation and development facilitation.[125] Coherently, Elshakry stresses the power of knowledge transfer for historiography and the construction of new ontologies in decision-making internationally.[126]

Considering the second potential of ICHSs for producing knowledge, it can be said that the HCM fulfills this on a local and global level. As in the example of survivors speaking at the

[122] International Conference on the Great Lakes Region (ICGLR) and Regional Training Facility (RTF), "Sexual and Gender-Based Violence in the Great Lakes Region."
[123] Raj, "Beyond Postcolonialism … and Postpositivism," 343.
[124] Dharampal-Frick and Ludwig, "Die Kolonialisierung Indiens Und Der Weg in Die Unabhängigkeit"; Chakrabarti, *Bacteriology in British India: Laboratory Medicine and the Tropics*; Amrith, *Decolonizing International Health*; Jadot, "Belgian Congo."
[125] Chakrabarti, "India's Medical Diplomacy."
[126] Elshakry, "When Science Became Western," 98.

UN, they become agents of their well-being and the greater good but also agents of knowledge produced in the global South. Particularly interesting is the following quote from the DMF's 2019 Annual Report:

> "We have facilitated South-South knowledge exchange and learning efforts between healthcare professionals, transferring expertise in holistic care from one (post)-conflict country or region to another."[127]

There are several ways the DMF facilitates knowledge about the HCM. Next to obvious applicable expertise such as the handbook, staff and survivors attend relevant events such as the UN Commission on the Status of Women. Moreover, they organize meetings such as the ICGLR, and target a wider audience through creative products such as movies.[128] This implies several things: firstly, survivors are given agency in the process of healing and developing and promoting the HCM. Secondly, they are given access to participate in debates at institutions such as the UN. This (a) makes the women relevant participants in knowledge production, exchange, and future policymaking and (b) makes the foundations' promotion of the HCM more legitimate.[129] The inclusion of civil society for effective and sustainable knowledge exchange and change in power relations is underpinned by Osuoka. He states that South-South civil society networks with shared historical experience have the potential to prompt change for civil society as well as for global networks.[130] This makes the HCM important for intelligence generation in international health governance.

As a catalyst of South-South knowledge exchange, the HCM can jolt consolidated colonial narratives about dominating knowledge systems while drawing attention to women's needs. It deepens the exchange of knowledge systems in the context of the foundations' advocacy network. Medie and Kang argue that there is an imbalance of knowledge production and merit between the global South and North.[131] The care model presents a vehicle to integrate the produced knowledge into other knowledge systems that function in a hegemonic narrative.[132] The decentralized advocacy presented at international institutions is crucial for enhancing the

[127] DMF, "Annual Report 2019," 34.
[128] Mouvement National des Survivantes de Viols et Violences Sexuelles en République démocratique du Congo, *SEMA: a film about survival made by survivors*.
[129] Tallberg et al., *The Opening Up of International Organizations*, 14.
[130] Osuoka and Zalik, "The Dilemmas of Global Resistance against Extractive Capital," 237; 254.
[131] Medie and Kang, "Power, Knowledge and the Politics of Gender in the Global South," 38.
[132] Amrith, *Decolonizing International Health*, 9–15; Harman, *Global Health Governance*, 4.

women's possibilities in local and global power dynamics.[133] Parmar and Álvez-Marín et al. support this, stating that the decentralized alternative knowledge systems are imperative for changing global constitutional norms, cultural assumptions, and global power hierarchies.[134]

It seems as if the DMF had implemented Andjaba's recommendation from 2000 to produce a gender-considerate understanding of protecting women's rights and health. The HCM can be considered a working implementation program for that understanding. This reiterates the need to pay attention to proposals of alternative ontologies and approaches to social development that originated in the field of health governance and ICHSs.

Nevertheless, this implies a connection between knowledge systems in healthcare, which is why the notion of "hybridity"[135] deserves more critical attention. Bhabha depicts the issues of fusing cultural identities. Romanticizing ICHSs can lead to a shallow, distorted assumption of medical or cultural innovation. It undermines the health model's real value and gives ground to neocolonial ontological hierarchy. Recalling the limitations of ICHSs, the gap between the involved actors' viewpoints could therefore (re)install neocolonial health systems, diplomacy, or unfavorable politics of knowledge. This falls in line with Bhabha's warning of repeating patterns of colonial hegemonic dynamics in the hybridity of culture.[136] Furthermore, this reiterates that underlying tensions in international relations are an obstacle to promoting and implementing an ICHS.[137]

Considering the women and the contexts they find themselves in, it seems almost cynical to examine the produced expertise through a realist lens focusing on competition. Competition, especially between knowledge systems, is the central limitation of ICHSs. The DMF provides a fitting disarming answer: "Sharing is also caring"[138]. The DMF provides care by producing and sharing knowledge about innovative health systems globally and vice versa. Scholars of colonial medical policies have shown that the optimal way of healing was often neglected for the sake of hegemonic ideologies.[139] Superordination in medical institutions has mainly led to suffrage and a neglection of health.[140] Caution is advised in prompting competition between systems that aim for humanitarian development and health. Integrating a focus

[133] Fondation du Grand-Duc et de la Grande-Duchesse, "Stand Speak Rise Up."
[134] Álvez-Marín et al., "Legal Personhood of Latin American Rivers," 175; Parmar, "The 'Big 3' Foundations and American Global Power," 679.
[135] Bhabha, *The Location of Culture*.
[136] Ibid., 159.
[137] Torri, "Intercultural Health Practices," 43–44.
[138] DMF, "Sharing Is Also Caring."
[139] Amrith, *Decolonizing International Health*; Dharampal-Frick and Ludwig, "Die Kolonialisierung Indiens Und Der Weg in Die Unabhängigkeit"; Harrison, "A Question of Locality"; Arnold, *Colonizing the Body*.
[140] Amrith, *Decolonizing International Health*.

on health into, for example, WPS might overcome a degree of escapism. Dahlberg, Todres, and Galvin validate this health philosophy, reiterating the need for diverse ontologies within healthcare and social research areas.[141]

Incorporating a health lens while investigating WPS issues can generate new answers. From a health perspective, it becomes clear that what the foundations and the hospital in Bukavu provide is, medically, a source of rich knowledge, scientifically and culturally, as well as of human value. Unsurprisingly, the DMF states that the HCM requires and promotes a health and "care philosophy"[142]. This philosophy provides the framework for women's agency in their healing and the HCM's development. Moreover, it practically strengthens the right to health.[143] The analysis of UN documents has shown that such innovative, locally developed, and implemented expertise can target human rights issues the international community has been discussing for decades. It would be interesting to know if Andjaba agreed.

The foundations and their promotion and knowledge production surrounding the HCM target global grievances in health policy. The DMF acknowledges that the HCM cannot fulfill its whole potential without addressing the underlying causes of its mission. The women treated suffer from illnesses and injuries related to CRSV. In 2019, CRSV had been used in the DRC as a WOW for two decades. The foundations' network, including the survivors, appeals to respective state- and non-state actors using their established knowledge. The knowledge produced in the context of the HCM is transported to ongoing debates on conflict. Thus, a health-related approach targets structural inequalities and deeply rooted international grievances while breaking with escapist notions of competition. Fouksman supports that this can cause sustainable change in the global order, stating that epistemic developments transcend notions of domination and subordination.[144]

At this point, I would like to react to the argument posed by Medie and Kang. They state that debates on empowerment and coherent developmental programs tend to overlook underlying root causes of power inequities.[145] This is exactly what the analysis of the HCM has provided: it revealed space for local and global female empowerment while drawing attention to the potential that knowledge production and exchange has for changing Eurocentric power dynamics. While healing, women become agents of their health and women's rights, but also of global power dynamics starting from the global South.

[141] Dahlberg, Todres, and Galvin, "Lifeworld-Led Healthcare," 265.
[142] Mukwege and Berg, "The Panzi Hospital One-Stop Centre Model of Care," 2.
[143] Ibid., 5.
[144] Fouksman, "Civil Society Knowledge Networks," 1866.
[145] Medie and Kang, "Power, Knowledge and the Politics of Gender in the Global South," 40.

In connecting these two entities, the HCM transcends shallow lamentation of power inequities. It targets the major criticism human rights politics have to face. Especially leading up to the late 1980s, the conflict between providing structural change and basic needs was characteristic of human rights in global politics.[146] Based on compassionate care and screening, women at the OSC help in advocacy surrounding CRSV and related health impediments. The model targets their individual well-being first, enabling them to become active agents advocating for communal development. This in turn, as established above, is beneficial for women in those healing communities. Thus, the HCM provides a cycle of development that encompasses individual and communal agency.[147] Finally, it appeals to countries and leaders of the global North.[148] It represents a bottom-up movement, which is imperative for local and global structural change.[149]

This analysis started with looking at the structural assets of the system's care, and how knowledge production can impact empowerment and global power relations. The next subchapter will look at the agency and participation in more detail.

Participation

Agency

As partly established above, agency is woven into the HCM's application and its production. This is how the foundations depict it and how it is planned. How is the participation actually carried out?

Agency and self-determination are especially given when people have the choice *not* to act. After the closure of care within the OSC, women are not motivated or forced to act in a certain way or take any further steps. The foundations and HCM staff do not assume that all women want to participate in decision-making and advocacy.[150] The women are not considered a generic group who all transform into agents of advocacy in a power discourse. Coherently, Mohanty underlines that women are too often assumed to have the same aims and interests.[151] The HCM carefully incorporates these concerns.

The HCM provides a double effect in healing and empowering women through intercultural, holistic care. It is a congruence of healthcare methods (as represented in the 4 pillars

[146] Normand and Zaidi, "The Right to Development"; Franczak, "Debt, Development, and Human Rights."
[147] PF, DMF, and Hôpital GR De Panzi, "Handbook," 29.
[148] *Nobel Peace Prize Lecture,* 3:19; 23:48.
[149] Gaventa, "Spaces for Change," 24–25.
[150] PF, DMF, and Hôpital GR De Panzi, "Handbook," 25.
[151] Mohanty, "Under Western Eyes," 72.

of care) with an incorporated understanding of societal issues. This forms an innovative means to tackle individuals' suffering and sustainably promote their agency in a wider regional context. As Gaventa suggests, such a complex helps tackle different forms and inequities of power.[152] This is ultimately relevant in a region struck by conflict and violence against women. This supports the literature review assumption that ICHSs can provide a channel for empowerment and include women's decision-making. Closing the circle, this finding supports Harman's note on the need to reconceptualize and strengthen health systems.[153] Increased attention must be paid to contributions in this regard from the global South.

Moreover, the HCM incorporates women's agency in standing up for their own health needs. It makes the survivors themselves the agents of knowledge production and exchange, instead of only acting representatively. From the survivors' perspective, the DMF follows the motto: "Nothing about us without us"[154]. This is one reason why this paper focused on the constituents of the health system and less on the women's experiences. The HCM gives the individuals ultimate control over if they want to participate in care and advocacy, but also over how.[155] This is especially important to overcome the narrative of women as passive victims who receive care. In turn, it creates agents who participate actively in their healing.[156] This strategy increases the possibility of a genuine, legitimate, and encouraged way of enhancing women's capabilities to speak for themselves and to contribute to change in health policymaking.[157] The model substantiates itself by implementing what it advocates for.

Providing holistic care that meets the contextual needs of the women enhances their agency also outside the context of the DMF and PF. Healthy individuals are more likely to access a state of mind or the capacities to get involved in policymaking.[158] Therefore, the HCM enhances the chances for survivors to speak up within and outside the foundations' network.

In the most adverse circumstances, the HCM gives space for women to be active agents in their health. Active participation is simultaneously a means and reason for women to be empowered. As they are survivors of CRSV, it is an example of how a health approach can produce grassroots, bottom-up change. The foundations stress that starting that process with medical care and socioeconomic and judicial support in the conflict-affected regions makes the

[152] Gaventa, "Spaces for Change," 30–31.
[153] Harman, *Global Health Governance*, 134.
[154] DMF, "Annual Report 2019," 17.
[155] PF, DMF, and Hôpital GR De Panzi, "Handbook," 18.
[156] Ibid., 27.
[157] Gaventa, "Spaces for Change," 31.
[158] Ibid., 30.

transformation from victim to agent more worthwhile.[159] Their agency in women's health and participation in decision-making is transported to diverse development spaces, such as the UN. Hence, by creating agency and empowering women in regions of conflict, the HCM is a relevant catalyst for women in policymaking. It presents a rare alignment of variables for change in power dynamics and policymaking spaces Gaventa looks for.[160]

The HCM, therefore, takes present issues such as CRSV and global inequities into account and provides what UN resolutions have been calling for. It heals women from the consequences of CRSV and makes them active participants of this healing process. Thus, the HCM's implementation implies that women consistently produce knowledge and co-develop the system. Thus, the HCM produces relevant expertise as to how CRSV and gender- as well as political inequities can be challenged. It demonstrates how women's agency can be enhanced exactly because it already does it. When it is implemented, it empowers women and allows them to participate in health policies. It is a multiplying effect of care, empowerment, and knowledge production. Theoretical models with limited source space or practical expertise can only go so far; by actually implementing it, the model criticizes current circumstances while highlighting what should be done. This makes the model ultimately effective.

The HCM impacts the participation of women in health policymaking in various ways. It fulfills an ICHS's potential in development, knowledge production and exchange, and agency. It creates a multiplying effect of healing women and making them active agents in that process. Through healing and overcoming the image of a victim, they participate actively in the health system's development. The evidence also showed that the DMF's South-South knowledge facilitation makes the HCM's implementation relevant for decolonizing international health. The HCM can therefore be considered a valuable answer to demands for strategies to develop health policymaking with the inclusion of women's agency.

6. Conclusion

The introduction of this paper addressed the constant demand for innovative health systems that enhance women's participation with sociocultural and geopolitical sensitivity. Women's contributions to health policymaking are crucial, but how can ICHSs enhance women's possibilities to make these contributions? This was the puzzle this thesis targeted.

[159] PF, DMF, and Hôpital GR De Panzi, "Handbook," 27.
[160] Gaventa, "Spaces for Change," 30.

This thesis argued that the HCM, developed by DMF and PF, enhanced women's participation in global health policy. The model implements a working system that gives the women agency and does what it urges other actors to do. Secondly, as women's agency is part of knowledge production and exchange, the model transforms the victim trope to one of agents being active in their own health matters and vice versa; it is a multiplying effect. Women participate in tailoring the model, and when it is implemented, women are empowered in turn. Finally, the evidence revealed that the model carries potential to decolonize international health governance. This is mainly due to the combination of its developmentary potential, production and exchange of knowledge, and the creation of space for the survivors' agency in the Global South. Hence, the factors that impact women's participation in health policymaking overlap with the potentials of an ICHS as presented in Chapter 4.

Applying postcolonial theory, this thesis provided a new perspective both on the debate of participation in policymaking and global health governance. On the one hand, the concentration on a healthcare model generated new answers for questions concerning gender-specific empowerment and changing agency in health policymaking. Moreover, the method illustrated how competition was the main point of criticism of the HCM's implementation.

The research was conducted through a deep, critical assessment of sources created by the foundations and UN institutions, backed up with the academic literature. Though this method provided a clear picture of the foundations and the HCM, it opens a window for diverse possible future methods to assess the HCM or other ICHSs. Different case studies could be examined with varying methods.

While the HCM's initial benefit for women's well-being as presented by the DMF seemed evidential, this thesis looked beyond the HCM's surface structure and asked about its characteristics with regards to women's rights and well-being. The qualitative analysis allowed for an examination with a specific perspective on the case. By testing it with consideration of historical geopolitical and international human rights contexts, the thesis could establish an underlying significance of the model for understanding and approaching women's health and participation differently, as proposed by Andjaba.

The HCM entailed numerous favorable factors for social development woven into its structural organization. The HCM's four pillars of care embody the model's sensitivity towards women's individual circumstances and the historical and political context of the Eastern DRC. This complex system can be applied elsewhere with the same extent of context-specificity. The implementation mechanisms were developed in a conflict region, which proves to be even more relevant for other locations in African and global conflict regions. Thus, the application of the

health system depicts a form of development in the care and social sector; it goes beyond healthcare and targets fundamental empowerment of survivors in the local context of Panzi and globally.

The HCM produces spaces for women's agency in four ways: First, it gives agency even before the process of care starts in the OSC at the Panzi Hospital. The survivors have complete control over what they want to be involved in. Secondly, through healing, the HCM recreates the possibility for a woman to use her voice. After care, the HCM provides a space to participate in advocacy networks, which involves the access to UN institutions and the establishment of further partnerships in South-South knowledge facilitation. This means that when the HCM is implemented, it automatically produces diverse possibilities for women to participate in the health system. Through this structure, the HCM becomes a living example of how to enhance women's possibilities in the field of global health governance while clearing narratives of passive recipients or victimhood. Future scholars could investigate how this could be implemented in other institutions.

The findings therefore revealed the HCM's potential for practically complementing UN human rights rhetoric. The theoretical approach is limited and requires practical expertise from the global South. Furthermore, the decentralized inclusion of knowledge can substantially strengthen and legitimize the implementation of this rhetoric. In almost a reformatory way, the sources from the foundations were complementary with concerns uttered in letters and declarations by UN staff.

Through engaging with sources generated by UN institutions, it was clarified how the HCM's expertise was complementary with targets in global health governance and WPS issues. Through its novel structure, which includes traditionally Western parts of care, and through its impact in knowledge production, the HCM goes beyond enhancing women's chances in health policymaking: it shakes up affirmed global power inequities in this area and questions conventional approaches to health, gender, and conflict crises. It carries the potential to evoke changes and impact in the South-North debate on global power discrepancies. The evidence revealed that the DMF's South-South knowledge facilitation makes the HCM an interesting subject for decolonizing international health.

Scholars have intensively investigated ways in which power relations can be changed and how decision-making can be increasingly accessed by women. The given case study depicts how ICHSs can be considered an unconventional, yet relevant variable that deserve more

scholarly attention. Scholars have shown that health diplomacy is a soft power,[161] and actors and interactions should be investigated more critically. Future research could, therefore, explore new ways to include health policy and diplomacy studies in IR as well as the development of a more health-based perspective.

Future inventions in this field can happen through criticism of the present and by taking present innovations, such as the HCM, into account. This also accounts for the case's specificity. The case is not understood as representative for the development of women's health and empowerment in general; it is connected to the field. It highlights a current development of women's role in health policy. It therefore urges scholars, policymakers, and medical actors to take the present findings into account. Though the implementation of the HCM is spreading, the lack of consideration of these specific cases is criticized. By doing what theoretical models fail to do, the HCM is an exceptional case of how it can be and is done. If taken into consideration, this criticism of what should be done presently can impact future inventions in the field of gender-specific and -inclusive health policymaking.

Health systems strengthening and women's agency are interconnected, and it seems that an ICHS such as the HCM meets the concerns uttered by Osotimehin and Khmelnitsky: new health policies and health systems are needed to meet present and future challenges, and women must be involved in this process. The DMF offers a concise answer to how this challenge can be approached sustainably, from the perspective of healed survivors: "Nothing about us without us."[162]

[161] Gauttam, Singh, and Kaur, "COVID-19 and Chinese Global Health Diplomacy"; King and Venkatachalam, *India's Development Diplomacy*; Kevany, "Smart Power"; Mol et al., "India's Health Diplomacy."
[162] DMF, "Annual Report 2019," 17.

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