EPISODE 57. DIALOGUES: A CONVERSATION WITH ALEX BREWIS

This transcript has been generated by the Trint transcription software and edited by TDR staff. The World Health Organization is not responsible for the accuracy of the transcription.

Garry Aslanyan [00:00:08] Welcome to Dialogues. I'm Garry Aslanyan. This is a special series of the Global Health Matters Podcast. In this series, I'll be blowing open some of the echo chambers that exist in global health. To help me in this quest, I've invited thoughtful and inquisitive individuals from different walks of life. Each of them has explored and written about global health issues from different disciplinary perspectives. I hope this dialogue series will give you, the listeners, an opportunity and space to step out of your daily routine and contemplate global health issues through a different lens. So, let's get started.

Alex Brewis [00:00:55] The most effective way to undo the damage of stigma within public health is to prevent it from happening in the first place. So, as a first crucial fundamental point we want to make in this book is that stigma should not be used in any way for any reason to promote public health. Doctors shouldn't be quietly shaming large-body patients to motivate them to exercise more. Workers in international development shouldn't be shaming people into building toilets either. That gets in the way of what they are there to do in the first place, to help communities thrive. Shame in all its forms needs to be removed from the public health toolkit because it so easily misfires.

Garry Aslanyan [00:01:35] For this dialogue episode, we take a deeper look at stigma and how often unconsciously we as global health professionals may be perpetuating it. I'm joined by Alex Brewis, Regents and Presidents Professor in the School of Human Evolution and Social Change at Arizona State University, where she previously founded and directed the Centre for Global Health. As a biocultural anthropologist, Alex's work crosses disciplines and partners closely with communities to uncover solutions to pressing global and environmental challenges. In this conversation, we explore two of her co-authored books "Lazy, Crazy, and Disgusting: Stigma and the Undoing of Global Health", and "Fat in Four Cultures". Alex brings both rich field experience and deep academic insight, helping us reflect on the intentional and unintentional impacts of our global health efforts. Hello Alex, how are you today?

Alex Brewis [00:02:45] I'm great. Hi Garry. Good to be on with you today.

Garry Aslanyan [00:02:48] So Alex, your research looks at how having less power, whether through social position or resource insecurity, can translate into poorer physical and mental health. Why does this area of work matter to you, Alex?

Alex Brewis [00:03:05] Well, first, let me just give you a quick definition of what we mean by power. Power is about being able to get or do what you want. I think this realisation that health and power were connected came pretty early to me because I started life living in worker housing in a fertiliser factory in South Auckland and New Zealand, amidst the trucks and the railway lines and so on, most of our neighbours were migrant labourers, making, I assume at the time, what was minimum wage. At some point when my dad had three children under the age of five, as the factory manager, he was asked to leave for agitating around what I understand was worker safety issues at the time. This is in the mid-1960s. And what happened was that while he left that job, it turned out that he was hired immediately elsewhere and ended up getting some sort of compensation for the rift. And so, what happened was we were able to move to a really lovely part of the city, a leafy beachside suburb. Suddenly my world changed very, very quickly, and I think it was in that that I realised that you can be in the same place and have these multiple realities going on that are very different for one lot of people from the other, and to me as a five-year-old, it wasn't that the people were any less nice or more nice between the two places. It was what people had available to them in their everyday lives, and it seemed really unfair, and I think since then I've always had an eye to what seems fair in life and what doesn't. I think that's a lot

of what motivates me, and in fact, one of my late great PhD mentors, Jane Underwood, once said to me that my Achilles heel was an overdeveloped sense of fair play. I've never quite figured out how to unravel that rather accurate insight, but I think it's become a driving force in the types of projects that I work on, things around water insecurity, healthcare access, stigma, and so on. And also, a lot of the places that I've chosen to do that work, like I've worked recently in Africa and Haiti and the Central Pacific and so on.

Garry Aslanyan [00:05:20] Alex, I'd like to maybe explore this phenomenon of stigma with you, which is something that we in global health don't often recognise ourselves as we're contributing to it or those involved in health. So, your book is titled "Lazy, Crazy, Disgusting", how do these three words reflect the stigma rooted in shame and what impact does that stigma have on people?

Alex Brewis [00:05:50] Stigma is a very slippery concept, everyone thinks they know what it means, but in fact, it means many, many different things. But in its essence, it's really about applying moral mealings to an otherwise arbitrary trait and using that as a way to devalue some people relative to others, to strip them of power, basically, a sense of belonging, opportunity, and so on. So, the lazy in the title comes from my very long-term work over the last 30 years or so on obesity and weight-related stigma, where there's a very strong public perception that being big bodied means somehow you're morally corrupt, you're lazy or otherwise lacking in strength of character. The crazy in the title refers to the stigma around mental illness, and that's probably the area that most listeners will recognise as an area in which stigma is obviously very important to healthcare because when people that have mental illnesses or are diagnosed with mental illnesses are viewed as dangerous or unpredictable, or these other morally discredited traits, they are treated differently in healthcare systems and outside of them, but also they feel differently about themselves. So, it's actually also a trigger for depression and mental illness in itself to be living with the experiences that stigma generates. Disgusting is really related to our work around sanitation and water insecurity and how people can be judged as disgusting by others for having things like unlaundered clothes when the reality is they don't have access to water to wash clothes, so they're being judged for in immoral way for what is a practical problem. And in all those cases, feeling stigmatised is harmful who to ever is targeted. It breeds the most painful emotion that we have as humans, which is humiliation and shame. So, I think there are not really any circumstances where you can say that stigma is a good thing. Experiencing stigma, we also now know as physiologically stressful. It creates a cascade of negative effects in the body, and now we're starting to see that stigma actually has intergenerational transmission through epigenetics. The trauma of stigma is sufficient to in fact create the types of gene changes that can be passed down to children or maybe your children's children in terms of genetic changes and the types of genetic changes that are not good for your health.

Garry Aslanyan [00:08:23] This is extremely interesting and I'm sure our listeners will appreciate. A couple of seasons back we had an episode also focused on dignity and diversity and global health and there's I see a lot of also layers to this how we approach certain things and thanks for those reflections. Alex, you've written about how disgust plays out in your work on hygiene and sanitation. I know these are words we use today. I'd like for you to share an example, maybe you could read a short extract from your book.

Alex Brewis [00:09:07] If there are many good reasons to practise basic sanitation by building and then using a toilet, why isn't everyone in Pemba on board with making and building and using toilets as a priority? Well, first, building latrines requires supplies that cost money that many families don't have. Second, water is often far away and expensive. Getting enough water to flush and clean can make maintaining toilets a real burden. Public latrines may help solve this in some places but are often unsafe for women to visit on their own after dark, putting them at risk of assault. And there are other

inexplicable cultural reasons in Pemba that even if people do have access to toilets, they nonetheless choose to defecate in the open. And so, in our interviews, people explained to us the pleasure of the ritual daily walks to the beachfront. It was a chance to unwind and catch up with friends. A smelly latrine can't do that. To people in Pemba, someone who defecates on the beach or in the tidal mangrove swamp is being social and practical, not gross and disgusting.

Garry Aslanyan [00:10:10] When you just talked about your experience in Pemba Mozambique, what caught my attention Alex was how much it showed the need to really understand people's perceptions before jumping in with well meaning interventions. Did you see something similar when working in Micronesia and other countries?

Alex Brewis [00:10:34] Yes, one of the reasons for the last few years I've been really committed to working with folks in USAID is been that early on I realised that these are people with the very best intentions sometimes, but this basic principle that anthropologists have, look before you leap, sometimes kind of gets missed in the shuffle. And I first kind of really became aware of how this works around sanitation when it was when I was working in the Republic of Kitabas, some gosh, 35 years ago now. I was doing very long-term field work on a very small and isolated atoll where you could walk from one side to the other in like five minutes. And people there loved to be clean. They'd wash several times a day in the ocean. They were incredibly dedicated to laundry, they were quite horrified by the poor quality of my own laundering skills, quite frankly. But the lagoon side of the atoll was used for ablutions. And the tide would come in and go out twice a day, like clockwork, and everything would be swept out to sea. So, when the development folks came in and built a toilet block in the middle of the island, people were kind of horrified and said, that is really disgusting. And in fact, it proved that they were right in the sense that when another group of international development folk came in later to test the coliforms in the freshwater lens, that was the well water, they found that yes, that was actually the case. But at the time, it was like people, you know, the intention was to stop people defecating on the beach. But people would say, why that's really disgusting that you pile all your poop in one place, you know, in a pit toilet. And so, of course, what they did was the toilet block sat there, and then the island council president or one of his staff came and put a big lock around the doors, so nobody would go in there and do what kids do when there's a spare space on a very small atoll getting into trouble because there's a door that closes, but it was to keep them nice and pristine. So, when the next lot of folks came in from out off island, that they could unlock them, and the toilets would look very clean and nice and yet people were like never using them. So that's when it was like all that effort going back and forward and if someone had just sat for five minutes and said to three people sitting on the edge of the beach, like, you know, we want to build a toilet block, what do you think of it? They would have explained that if they'd actually listened and you know, maybe asked the question a couple of ways, which was probably going to be more performative than practical in that situation. And since then, I thought, you know, it's this sort of anthropological take of stopping and listening first is really useful in a whole lot of circumstances, and often we think we know how things work. I mean, I do this all myself, you know, I make quick judgments about how things work and often when you back up and look at it again, you're like, oops, I didn't really understand it the way I thought I did, and if I just stopped and asked a few people, I would have got a different take on this.

Garry Aslanyan [00:13:49] You also write that when shame and disgust collide, they permit cruel mistreatment of whole people groups by releasing us from the obligation to show empathy. Can you expand on this idea and the consequences you've observed of this kind of approach around the world?

Alex Brewis [00:14:11] Yeah. So, as I noted, one of the challenges with addressing stigma or even noticing it is humans are by their very evolved nature very adept at judging and judging other humans.

And it makes sense for a hypersocial species like ours to have some sort of cognitive mechanism that helps us stop and say, are these people that might hurt me? Are these people I should invest in as trade partners or marriage partners or whatever? Will they make me sick? And I think that made a lot of sense in the past before we had public health institutions and legal frameworks that would sort of organise a lot of this information for us and tell, you know, sort of provide some guardrails to make these sort of very quick heuristic decisions about who's in and who's out of our worlds, right? And why, but that human capacity to sort of focus on difference as a way to decide who's like us and who's not and do that all the time in our everyday lives, is a very human trait. But the problem with it is that it becomes attached to things in a very arbitrary way, whether it's religion or skin colour or country of origin or occupation and so on. So, I was working in Haiti in 2019, and I encountered amazing dedicated, ethical, optimistic people working hard to deal with extremely challenging circumstances, lack of security, lack of food, lack of opportunity. But you mention Haiti to anyone in the US who hasn't been to Haiti or hasn't had the time to really listen to what Haitians have to say about the situation in Haiti. And they feel permitted to say really dreadfully and stigmatising things about Haiti that are based on very arbitrary perspectives of what goes on there and who Haitians are. And it permits discrimination, not just by individuals, but by agencies and nations too, these types of arbitrary, stigmatising notions, what people are that are different than you, that you don't understand their circumstances. It affects then what agencies and so on are willing to do or feel fine about denying or ignoring. I mean, often stigma is not just about doing, it's also about ignoring or excusing, and in that context, you can see stigma very clearly as a tool of power. If you control the conversation about different groups and their moral worth, you can then justify any amount of pushing them down, pushing them away for the benefit of the institutions you care about, to the cost of the ones that could serve them. Whenever I look at a situation where people are being stigmatised, I am always then asking, can we bono who benefits? Because you can't really have stigma amplified without power, because that's the driver underneath it. In a situation where we are socialised to make meanings of these arbitrary distinctions, country of origin, for example, which can be then used to really discriminate in harmful ways. And it takes real effort to question these assumptions. And I think, particularly in the social media age, it's even more challenging. At Arizona State University in our global health programmes, we try to build skills and what we call structural awareness, which is a really a way to help professionals navigate this by at least being able to have a sort of a bit of a radar to be able to see these processes at play, these stigmatising processes. And when you see signals of what sounds like stigmatising language, and there's a lot of them going on right now, that you're able to sort of notice and be aware of those, but also how be able to see it in how institutions are organised and what institutions are doing or not doing. And being able to put those two things together. And it's very difficult to do without a really good framework for understanding how power works and all of that, because it explains the connections really well that are otherwise completely invisible. And the book was really part of this effort. We wanted to write a book that was working towards this goal to give people a better sense of how to recognise and react to stigma as a structural impediment that people face, not just an individual experience. And when you're training health professionals like we are, that's important, I think. I think it adds a whole other dimension to a career, to a life, you know, a lifelong learning, to be able to have some real awareness of some things that are going around you that affect other people that you might not have been aware of.

Garry Aslanyan [00:19:14] Alex, for the second half of our conversation, I'd like us to turn to a current area that you have been working and exploring, how fat has become a word loaded with personal failure or blame and shame. You describe it as being treated as a worldwide epidemic of laziness. When considering history, perceptions of fat haven't really always been the same. How did these ideas evolve? Maybe you can share some insights from your work and why do we now see fat framed as a global phenomenon?

Alex Brewis [00:19:56] So I started working in Samoa, which was then Western Samoa in the early 1990s as part of a very large National Institute of Health study of cardiovascular disease in what was then considered one of the highest average body weight populations in the world. And I came on to do a sub-study on very small one on body image, asking people how they felt about different body sizes, which were being measured as part of this larger medically focused study. At the time, people were really pretty positive about their bodies and especially large bodies, seeing them as strong and capable of hard work and a relative sign of affluence in some cases. Then I went off and did some other things in the meantime, and then in the mid-2000s, I went back to this work on body image, and we decided to begin thinking through some of this stuff, and we did a global survey to sort of test where different places were in terms of anti-fat thinking and sort of stigma around large bodies. And so, we were like, well, I knew from my experience in Samoa in the early 90s that was probably a place where people were positive, and it turned out all the places we went, that was not the case. And it didn't really matter where we were, the sort of local framings might be slightly different, but whether you went to Samoa, to Argentina or the Middle East, people all like, big bodies are bad, big bodies are undesirable, unattractive. And I think one of the most interesting findings for me, just as a titbit, was women in burkha's in the Middle East, is so you have, I have a colleague, Sarah Trina, she was doing research with women that were in a women's university, but you know, they were wearing burkha's, so their bodies or their bodies were fully covered. And yet, interestingly, young women were very concerned about their body size and often dieting, because there was this sense that a larger body was a non-modern body. It was the body of grandmas and mothers, and to be a young woman, you can still see the outlines of size, even when you're fully covered. So, that to me was like, yeah, that's a signal of how embedded this is now in sort of modern consumer culture, sort of capitalist neoliberal ideologies. It's like anywhere where people are interacting with the modern economy, they're concerned about the body because a slim body has a certain capital now that it didn't have before. So, we've seen just really surprising changes. The extent of the changes that's most surprising. Another really good example of that, in more recent was I have a colleague Jonathan Maupin who's worked in the same rural area of Guatemala for at least two decades, and he has been working with children and body image. And he's said that as early as six, seven, eight, kids are able to negatively place negative sort of moral attributions on bodies that are larger or small, that's rural Guatemala. And by early, you know, pretty early in childhood, you see this stuff having traction and how people are thinking about the world and thinking about themselves. And that's when I realised this truly is a globalised phenomenon, and we just can't think about it as being just in some places and not others anymore.

Garry Aslanyan [00:23:48] Let's hear a reading from one of your other co authored books, "Fat in Four Cultures".

Alex Brewis [00:23:56] This section was written in a co-authored book by my collaborator and co-author Jessica Hardin, who's done research in Samoa more recently than me. Given the Samoan emphasis on family, it's initially surprising that laziness in Samoan Apia was cited as the culprit for fatness and diabetes. But this discord of laziness circulated widely from informal conversations with the healthcare providers to the daily newspaper, the Samoan Observer. The Prime Minister said, there are plenty of mangroves, porpoise, and bananas and breadfruit falling off and rotting on the ground, and plenty of fish in the sea. The problem is too many people are coming into town and loafing around. They are lazy and do not want to get back to their village to work the land. They should stay in their village where their lands are and develop it, he continued. Some Samoans think that not having a car, a TV, or a European house is poverty. Those are luxuries. Having none of those is certainly not poverty. So, the Prime Minister's comments generated a lot of discussion in Samoa about who can determine what is a luxury and what is a necessity. And this basic idea shared by many suggests that responsibility and blame cannot be assigned without attention to its multiple levels of context. On the first level of the household,

the village and the church, on the next level, the nation, and finally, on the third level, are the global food trade and transnational migration. Laziness was thus articulated at multiple levels to express ambiguities that arose around changing food norms and rising inequalities.

Garry Aslanyan [00:25:32] Samoa is among the countries with the world's highest obesity rates. Alex, what has been the effect of obesity and diabetes public health campaigns in this country?

Alex Brewis [00:25:45] Yeah, just to clarify that back in the 90s, Samoa had some of the highest so-called obesity rates in the world, but everyone else is caught up since. So, I think we have to be realistic about the situation when you have a lot of countries like the US and UK, where two-thirds of adults are technically overweight or obese in clinical terms. So, the WHO Global Strategy on Diet, Physical Activity and Health, like many others, continues to advance on the point that individual responsibility is called a body size. This is a very stigmatising idea. It's really embedded in sort of the health behaviour change, sort of thinking about weight. And there's always in that, some level of blame and shame. And I think that this is part of the challenge. But the first thing to know about Samoa is that people have been coming there for decades. NIH studies, development projects, medical missions, whatever it is, with ideas about how Samoans could have better diets and exercise more in order to deal with their problem, as it's framed, of weight. And that's things like, you know, there's these recommendations for growing more local food, encouraging exercise at community competitions and events. At best, with all that effort over several decades, the rates of clinical obesity have plateaued. It's been a cacophony of anti-fat messages for decades. People have been told that big bodies are unhealthy, and social media has really doubled down on that messaging. But I think the interventions themselves, we could argue have helped fuel anti-fat views, even as they really haven't achieved their goals of helping people on average lose weight, their own sort of population level stats of clinical obesity and so on. And the constancy of interventions there without real results means that people now are extremely wary of people coming in and telling them what to do in this regard. And beyond that, the absolute focus on weight is a moral reflexion, means that a lot gets lost in the mix on discussion around how to create healthy communities and places like Samoa, but also everywhere else. And you see that often a lot of those interventions don't even fit with the constructs of people's everyday lives. You know, people are asking, is the intervention serving life goals or is it just serving people's life goals for how they want their families to be, their bodies to be, their lives to be? Or is it that we're just sort of chasing after some external marker like BMI? These are pretty tricky questions, but I think in places like Samoa, they've been hearing this stuff for decades to little effect. I think there's some good reason to be a little critical of some of this thinking about how we think about different countries and their obesity rates.

Garry Aslanyan [00:29:08] Right, I mean I don't know, I actually remember reading a study about Turkey tails and obesity in Samoa. And there was a real interesting trade and health and culture study that overlaid all of this together and how the perceptions of fat and in food and then how they were f fighting but at the same time it's part of culture. A very interesting situation.

Alex Brewis [00:29:39] That's a wonderful book.

Garry Aslanyan [00:29:41] Yeah.

Alex Brewis [00:29:41] Yeah, actually I'm forgetting the title right now, Sheep Flaps and Turkey Tails, something like that.

Garry Aslanyan [00:29:48] Maybe, yeah, that might be it. Yeah.

Alex Brewis [00:29:50] But the book's really interesting and we have our global health students read that book actually in our class on food and culture, among other things, because it does a really good job of showing that you can be thinking about what's happening in a country, but there's all these global processes that affect things like weight, and in this case, it was the argument was that, and a convincing one, that New Zealand was using its lamp flaps, which is an off-cut of meat that's very, very fatty, that doesn't sell in New Zealand and shipping it to Samoa where it would sell there, so you had this sort of international trade situation that was driving the consumption of extremely high fat meats because they were a cheaper part that someone was happy to send off. So, all these things don't happen in a vacuum anymore for and it's just accelerating that you have to sort of think about these things in a more global context. And that's a really good example of that sort of thinking that anthropologists do. They can be really useful.

Garry Aslanyan [00:30:50] Right, right, and if we pick up on the anthropological side of it, we know that things like structural factors, cultural values have big influence on people's weight, and you've given all of that already. But we still as public health people, still have this narrative to put so much blame on the individual. Why does that continue, Alex?

Alex Brewis [00:31:23] Well, I think there's several reasons. The first is that it's the cheapest, easiest intervention. Structural interventions are complicated and expensive. And just think of sanitation, you know, providing toilets and water hookups for everyone that doesn't have a toilet in the world is beyond the capacity of all funding agencies put together. It's just extremely expensive and then there has to be maintained. So, at one end you have in a clinical sense too, sometimes it's easier just to tell someone to eat less, exercise more. Or try and channel people to building their own toilets than it is to think about more systemic solutions. But I think we also have to look at sort of the thinking that goes along with contemporary life and particularly sort of like neo-liberal notions of individual responsibility that underpin a lot of how people increasingly see the world and this idea that your success is based in your own ability, not understanding how advantage and privilege works. But then also your failure must be rooted in individual responsibility as well. So, if you are not able to lose weight then you know that's because you fail. If you are able to lose weight it shows that you're a success. So, it's like it's tied to these ideas that I can prove I'm successful by being wealthy or being slim or these other markers that maybe other people can't quite access the way that I can but I'm going continue to frame the world in terms of the belief that they are because then that says that I'm a success compared to other people and humans are very status aware creatures. And we do like to organise the world in terms of often if we're doing better than other people. Humans love a hierarchy, it seems, but they only like a hierarchy if they're on top of it, so that sort of drives, I think, a lot of the sort of broader context in which this is happening. And I do think the sort of, you know, how in healthcare and public health, the behaviour change model has been king or queen for decades. It just is, and it's not just because it's often easier to use that as a solution or frame that as a solution, but also, it's easier to understand, right? It's easier conceptually. Structural stigma and disempowerment is harder to understand and is harder to sort of trace. So, I think, you know, it's also an attractive way of seeing the world for humans in multiple dimensions in a modern global economy.

Garry Aslanyan [00:34:29] Is there anything that as a global health community you think we can do to think differently about reducing stigma and sort of kind of a blame kind of approach to things. And of course, our listeners also in their own day to day work, obviously all of us have stigmatising thoughts. How do you at that personal level, get over that approach that maybe still is with some of us? So, any thoughts of as a community, those working in health and global health and also what we can do as individuals?

Alex Brewis [00:35:26] So, in terms of as professionals, I think one of the important points in the book, and we do lay out at the end of the book a sort of a guide for how to sort of think through this thing in the right situation. What to be aware of? And I think that's super helpful to have a sort of checklist that we put in there to help people identify how relevant stigma is to their particular situation, and sometimes it's much more crucial than others. And if you sort of have a checklist, you can sort of say, okay, this is something I should be thinking about, or this is something that I have to focus on, right? But I think the first, the first sort of hint is don't treat stigma as an afterthought. Consider its role in projects from the start and sort of have some sort of assessment of where the risks are and what they might look like. So, that way you can have some sort of concrete starting point to ensure that you are doing things the way that you would like to, in terms of not doing harm. But also, you know, the interventions that take this into account tend to be more successful anyway. So, it's a very good, just good practise in terms of effectiveness in our jobs. I think we have to ask questions like, you know, do people account for this health risk or medical condition as being cultural? Like the moment people say that that's a huge red flag that you are into stigma territory. Are we expecting individual behaviour change? That's also a really big red flag that you might be stepping into stigma territory. And in this way, I think it's really another thing that I'm very wary of is some of these efforts to sort of deal with interpersonal prejudice, like anti-biassed training is probably my most frustrating, training to try and recast the wiring of people's brains, that is practise ways of thinking doesn't really work, so this sort of anti-biassed trainings are often trying to reprogram how people think, but the research shows that quite quickly people go back to thinking how they were, but they might get better at performing non-biassed in a non-biassed way, even if they're still thinking it. So, I think that approaches that see what's going on as interpersonal prejudice really fail to miss the mark on where the important change and intervention needs to happen. You need to address stigma as a structural problem, or it's not going to go away. And training to do that, I think should be part of every, certainly every clinical, every medical school curriculum. I think we're in a world where things seem to be slipping and sliding in ways that permit and encourage negative judgments, prejudice, you know, devaluing some people, pushing them down and out further. So, I do think you know this is also about being aware of one's own thoughts, you can't stop thinking these things, but it's how you react to them that matters. So, as an educator, I always come to solutions with that in mind. And I think self-education is key here. So, whatever you do, reading about other lives, literature is probably one of the most powerful tools we have. And I think it's not often appreciated, I joined a book club a couple of years ago, and it kind of brought me back to this thinking that oh, we can really learn a lot about our own thinking and other people by reading more. Getting to know others that are not like you, socialising more widely. I think there's lots of things, asking questions when you talk to people and listening, being curious. These are all the things that I think help you get out of just automatic thoughts that become unqueried and become harmful to others in ways that maybe we don't even notice that we're harming others but do. So, I think it's knowing we can do better and working towards it is the answer. But like everybody else, every day I'm like catching myself and thinking, how can I do better? And that the people I know that really think this way and act on it is people that have some of the richest lives I've ever seen. So, it is part of the pitch for it, I guess, is that it does make your own life better to be thinking in these ways. Because empathy is about seeing yourself in others, right? And the solution to stigma is empathy. Just about sums the book up.

Garry Aslanyan [00:39:59] Very interesting thoughts and reflections. I really enjoyed this conversation, Alex. These are very complex and sometimes maybe not well thought through situations and concepts that we don't step aside and reflect. So, this I hope helped me and I hope same with the listeners to dive a bit deeper into this and thanks for all the work that you've done on this. I wish you best of luck for your future endeavours.

Alex Brewis [00:40:32] Thank you. It was a delight being on the show and talking with you, Gary. So, thank you very much.

Garry Aslanyan [00:40:38] This conversation with Alex Brewis really made me pause and think about how stigma quietly seeps into global health, even when our intentions are good. Alex reminds us that shame has no place in public health. Whenever we use stigma to push change, we end up weakening trust and silencing the very people we want to support. She also urges us to slow down and listen first. Real impact begins with empathy, with understanding people's daily lives and the realities behind their choices. And finally, she highlighted that empathy itself is the antidote to stigma. When we stay curious, examine our own biases, and approach others with humility, we open the door to more compassionate and effective global health practise. I hope this dialogue leaves you reflecting and encourages you to put empathy at the heart of your work. To learn more about the topic discussed in this episode, visit the episode's webpage where you will find additional readings, show notes, and translations. Don't forget to get in touch with us via social media, email, or by sharing a voice message, and be sure to subscribe or follow us wherever you get your podcasts. Global Health Matters is produced by TDR, a United Nations co-sponsored research programme based at the World Health Organization. Thank you for listening.