

Michael

DD: Describe yourself in three words.

RES: A Father, a son and a friend, probably.

DD: Hi, everyone. Welcome to the Global Health Lives podcast. I'm Delan Devakumar and today I'm with Professor Michael Knipper. The soon to be appointed professor in Global Health, Migration and Medical Humanities at the Giessen University Medical School in Germany. Michael is a medical doctor and anthropologist who spent many years working in South America and now works primarily on Indigenous health and on migration.

RES: Thank you, Delan, for this invitation. It's a pleasure to be with you.

DD: So we first met in the Lancet Commission on Migration Health. I remember having long discussions with you about migration obviously, but also many other things. You always had such a thoughtful approach to topics, taking a historical and anthropological lens. Also with a strong human rights argument. Can you tell me what drew you to work on these issues and work in the way that you do?

RES: That's an interesting question. It probably had to do with working as the physician in the Amazon. I saw these inequalities in equities, the difficulties of the people to get access to healthcare, for example. The dimension of exclusion and racism, probably. That was when I was working in Ecuador. But at the same time, when I was studying medicine in Germany. I had a group of friends from Latin America who lived there as undocumented migrants. This threat of being deported, which was their daily life and their daily fears, I was very much impressed by this. At the same time, by the privilege that I have being raised in a German family with a German passport, with a rather wealthy, socially established environment. Nothing was questioned in this way. When I was sick, I could go to the hospital and when I saw a policeman on the street, I did not have to be afraid. But my friends were very much afraid. That was kind of a sense of injustice that drove me probably into these topics.

Then I learnt and when I worked as a physician, I think I was always more interested in the people and their stories than in the disease. I was much more keen to talk to the people, to learn how they lived with their disease. Especially I remember some families with children in

difficult social situations. I like to listen to their stories and then to think with them how to solve that problem.

DD: It takes me back to working in paediatrics. I remember working with a child psychiatrist, and he taught me to start with the family tree. Who's there in the child's life and build this story of the child and then progress to whatever they're presenting with. Going back to your own childhood you grew up in Eifel, near the Belgian border in a large family with six children, and you were the second youngest. This sounded like a very vibrant household. In addition to the family, there were lots of people coming and going. There was lots of political discussions, engagement in politics at a local level. This must have been an interesting time, particularly in that generation, post-World War Two, but pre-unification with the fear of Russia and the Cold War around as well. Can you talk about growing up at this time in Germany?

MK: Yes, thinking back, that's a really different historical time, actually. The Eifel is a beautiful but very kind of lost region at the extreme west of Germany, close to Belgium, not very much open to the world, actually. So I was born there and raised there and loved it. At the same time, it was very far away from everything from my dream of leaving it. But my family was, as you told. We have six brothers and sisters and my father and my parents are very open to invite people from other places. That inspired me very much. At the same time in the region where I was growing, in the backyard of our house, in the woods. There were some of these bunkers from the German World War Two. I was looking still for arms and for bombs with my friends from the Second World. So this memory was very much present.

At the same time, we were in a very, very peaceful time, with a stable, but peace built on fear from the from the Cold War. There was always this fear from the Russians to invade Germany, actually, in the high time of the Cold War. I was living on this and really wake up at night, afraid of probably tomorrow the Russians would invade Germany. At the same time, my father was very much dedicated to international cooperation and looking for a peaceful future. So very much engaged in the reconciliation with France, for example. That was the family I was growing in.

DD: So then in your late teens, you had this profound event in your life when your father died. That led you physically away to South America, but also towards a career in medicine. Can you describe that period of your life to the listener and how you coped?

MK: Yes, I was 16 years old, I think, when my father fell ill with cancer and heart disease. It was a shock for all of us, for my mother, for my brother, sisters and for myself. You never imagined that your father can die, even though it's possible. He always in the hospital, tried to give us optimism and to make fun of everything and so on. So I remember him very optimistic. My eldest brother went as a journalist, together with his wife to Bolivia at that time. He always sent us letters from Bolivia. We learnt through him about work in Bolivia and he started a support project for local soup kitchen. My father and I engaged very much in supporting the soup kitchen. In that time, I developed a plan together with my father to go there and my mother. After finishing high school, I would go with him and then stay there for a year to work in this project.

Then my father died when I was 18. It was terrible, actually. Then I was, I remember this time, it was a few months before finishing high school, before all the exams. I never was very good in school and always focussed on other things. So I did it and got some grades which were okay but not really good. Impossible to think to go to med school, but I finished. Then my only goal was to go to Bolivia, to work there and do what I can. Probably accomplish the mission I created with my father.

But at the same time, I think it was the young person completely lost. Then I came back and as I did not want to go to the Army, which was an obligation at that time. I went as a substitutory service to the hospital and nursing. Then I started to work in the hospital. I think the decision to go to the hospital was directly the consequences of seeing my father suffering the hospital. Because I know that he suffered very much in the hospital. I thought that was not good. It could have been much better. I think that was for me, a way of coping with this personal story. Then I had to work 20 months in the hospital and nursing. So I had a very close relationship to nursing. In nursing, you are very close to the patient. I still remember some of these patients of that time. Mainly older men of the age of my father, close to dying and me being very close to them, and of the family until they finally died. That was probably something that brought me to medicine.

DD: So while you were in medical school and also after qualifying, you spent a long time in Ecuador. How did you initially get the opportunity to go there?

MK: I studied medicine the first three years in Germany and accomplished everything. Then I was completely bored by med school, because it was only studying and learning and getting exams.

I really had to leave or to quit. So I had the opportunity to go to Spain for one year with the Erasmus programme and I spent a lovely year in Asturias in Oviedo. There I met a professor for the history of medicine. Because I was looking for a possibility to go to South America and told him about my plans, and he said, oh, I have a friend in Ecuador Dr Eduardo Estrella was founder for the museum for the history of medicine. I wrote him a letter from Spain. After only three weeks, I had the response, which was really fast at the time. He said to me, he responded very kindly, saying whenever you want, you can come join us and we have plenty of work for you to do. So you are very welcome.

Then I went for six months to Ecuador, only with this letter in my hand. Then I started Ecuador. I met Eduardo Estrella. I met his younger colleague, Antonio Crespo, who was a very good friend until today. Then I started with some clinical jobs in the hospital. I found it terrifying working there in a public hospital, actually, because it was in gynaecology and obstetrics. The violence against Indigenous women was so terrible that I quit it before the time actually. But I have to correct myself, I met incredibly good and nice and committed physicians. But the structures and all the general environment was very violent. We know that especially obstetrics is a very violent area of medicine sometimes. I left the hospital again. Then started to look around for health projects. I met some people and went to the Amazon and there to the hospital in Nuveo Rocafuerte which is in the border between Ecuador and Peru. That's one of my most favourite places in the world and the lovely small missionary hospital. I learnt to know Dr Manuella Munares the physician, who led this hospital giving very high level, high quality service to the people at the same time. Permitting the people, being themselves in the hospital, speaking their language and having the family trust them. Some other physicians like Javier Ratnares and another Spanish priest and physician who lived there in the communities and work with the communities. He took me and through him, I learnt what community health is and primary healthcare. I was deeply impressed and I found myself, that's the place where I want to be. That's the area I want to work.

DD: So you went on to do your PhD with the Napo Runa people in the Amazon. I spent a short time in that part of the world with colleagues from the University of São Paulo who work in Acre State in north western Brazil. I think that the city was maybe a little bit different. It was this small city on the edge of the Amazon Cruzeiro do Sul. It felt a little bit like a mixture between another more usual Brazilian city, but also a very different country. Can you describe what it was like living there? What it was like being accepted into the community? And the work you did in your PhD?

MK: It's at the margin of the Amazon going to the Andes. You get there. Well, there is this border city of Cocha, where you can go now by plane and take a boat. Then you'll need about six or eight hours to come to the village where I lived and about 12 hours to the hospital. That was for me the reason to go there. It was kind of far away from everything. I found it simply beautiful, this Amazon region. At the same time, I took time. I came there in 1992 or 1993, the first time, and met the people. Then I only started my research in 1997 after graduating after, working as a physician, after having the grant for permitting me to go there. Then I had really good contacts to the people. So many people knew me already. Then I selected one village where I could live, it's called El Eden. Eden, name from the Bible and the paradise, actually. I asked the community if I could live there. There was a very active community health worker, Santiago Santi, from this village and I knew him before. He presented me to the community. I told the people that I want to be there. I want to live there as a physician. At the same time, doing this research, which deals with Indigenous approaches to health.

The people knew about it, but they saw me mainly as a physician living there. That would be kind of helpful and useful. Then I took time and I did not insist directly and working only on the research. First, I wanted to be there and know the people and that they had the possibility to know me. That was really funny being the physician there. The first time there were people, a large group of people coming to see me and to see the doctor and from other villages of the region, the whole canoe there's 20, 25 people going to the doctor, but they were not sick. They only complained about something. They wanted to test me I think. They wanted to know me as a physician. I was able to talk to the people and engage with the people and hear their stories. I think they liked that I had this attitude of listening and engaging. That I not only focussed on the disease, but it was very well run primary healthcare project, there's medicine and so on. My colleagues from the village, the community health workers who are really well trained and so we worked together. I think very good and I enjoyed it very much.

DD: And your work was partly to improve quality of care for the indigenous people in particular?

MK: Well, that was my idea. What can we do to improve access to healthcare and quality of care for the people. We did it at the local level, and I learnt very much. The importance is to listen to the local population and how they perceive, for example, the health projects, the hospital and the political interventions, the [non-governmental organisations] NGOs and so on. I had time to listen and to accompany patients to the hospital. Both to Nuveo Rocafuerte, to this small missionary hospital, which worked very well, I think. Also to the state hospital in the

provincial capital, which was a different experience. Where I also perceived that patients who entered there were not treated really very well and did not get treatment at all and so on. That was the environment.

Then I wanted to learn about the perception of the indigenous communities, about health and disease. I learnt from my anthropological studies that their people speaking of the traditional medical system, of Indigenous communities, for example, with their healers and their shamans and treatments and specialists for different types of diseases and was specific notions of diseases. On the other side, also the Western medicine and you can read much about cultural differences in healthcare. People have cultural barriers and understanding and communicating about health and disease. I found this kind of too schematic and I learnt that there is no such kind of symmetric Indigenous health system compared to the western one. Because the western one is of western construction. There's no need that Indigenous communities and societies create the same, only in Indigenous terms. Even the notion and it's probably my historical background, the notion of what is medicine and what's a physician and so on. That's historically created by our society. You cannot presume or assume that this is the same in Indigenous communities.

So, I learnt very much about collaborating and about different perspectives on disease and health. That was really fascinating. How disease and how it is perceived from a very different lived experience of being a human in this world. Being born in an Indigenous community and raised in an Indigenous community is completely different to what my life was. At the same time, the needs we have, the need for social relationships, for support, their feel of pain, a fear of loss are very similar. We have lots of common ground. Then the notions that I, as a physician developed, for example, when I had a patient with pneumonia. I saw there was pneumonia, there was fever, there was probably a germ. Then I give antibiotics and it works. But what I see in the patient, the others don't see. They see the suffering, they see the symptoms, but they interpret this in a different way, relating it to different lived experiences. But they don't exclude my perspective. It was very easy to join and at the end, after a more than- It took me a year and more than a year to have really contact to the Indigenous healers, to the shamans, as it's called internationally. The local term is yatchak It's not only about diseases and illness, it's also about everything else in life. They are knowledgeable people. To collaborate with them was very good and very nice. We worked very well together, saving patients together, actually.

I learnt one or two very important lessons from my indigenous colleagues and collaborators in this work. Which really accompanies myself through my later work in global health. First one was that they talked about all these strange people who show up there. It can be missionaries or priests or people like me, researchers and people from NGOs. They said to me, they always come in the zancudo style and zancudo is a mosquito. They come, they pick and they go. They don't like this so much. They really want to get to know the people. They feel sometimes also abused.

When I was working, especially, Santiago Santi my Indigenous colleague, community health worker and neighbour. He told me when we were discussing about the research that I wanted to ask people something and asked for definitions to explain this concept of disease or this notion of disease. So, he said to me, "Michael" or Miguel, "I will no longer work together with you, because you have this crazy tendency to put everything in boxes into this German or European or whatever boxes. It's not only this or that, but you have to think, in both it's true and you have to be much more flexible and we're really upset with you. So if you don't change your way working, I will no longer collaborate with you." I was kind of upset with him at this moment, because I had to write a report and wanted to have things well worked out, but it was impossible to write any table. I felt for a moment that all my research was kind of challenged and probably threatened to be in vain. Then I reorganised and I reconsidered my perspective. Yes, I changed my attitude in research.

I think until today, until today, I'm very critical with everything with all these. I think we need definitions, but we have to be flexible with definitions, have to understand what the background of the definition, What's the purpose and what's the purpose of categories and so on. We have to be aware of the categories. The same category can be understood different by the same people. They all are. Right, but it depends very much on our personal experience, how we perceive. These categories are now neutral words or technical categories or means, only they have much more significance. If you are from a community that has a history of suffering, of exclusion and so on. These words are not neutral and these categories are a neutral. The process of categorising is not only including, it's also excluding.

DD: So then you return to Germany and faced the situation that many people face who work in global health, that are colleagues are progressing ahead and you come back and you don't quite know what to do. For me, that was changing from clinical paediatrics to public health. For you, you went into tropical medicine briefly and then into the history of medicine. Now

you work on migration and health. Can you talk about some of the work you've done in migration and that kind of transition when you came back to Germany?

MK: First of all, the experience was great and kind of exotic, what I had to tell. But then it was good and nobody really understood what I did, especially in the professional world and the academic world. I remember when I was applying for jobs as a physician, and I learnt that everything what I did was meaningless for the others. What for me was the most important experience of my life. For all the other people in my professional environment was kind of useless. I was a failed physician and that was really tough. But my partner close to marry and we had a child and so it was kind of economically challenging. Becoming a father was- You may know this, changing everything. I feel so blessed with these two children.

I had the possibility from the University of Bonn and Hans Schott and colleagues and then Volker Roelcke who is now the head of my department here in Giessen. They opened me the opportunity to work in the history of medicine and to bring together this, anthropological with the historical lens on this issue between health inequities and intercultural issues, relate to this. You have social medicine of the history of the primary healthcare and so on. What I find really very important as a perspective, because the discussions we have today are not necessarily new. The history of a very good ideas in medicine and public health that have not been pursued. There are many possibilities to think differently about health, public health, health inequities and how to solve them. I think the historical dimension opens our scope of what we can think.

Then I got this job in Geissen in Germany. It was a time when Germany was discovering a little bit, oh, we have migrants in Germany. We have kind of a multicultural society. It was many parts of society did not want to acknowledge this. There was a stronger acknowledgement of this multicultural composition of the German society, and that the guest workers are not guests, but our co-citizens, that they are part of our society. There were very interesting discussions about the cultural differences in healthcare between Germans and others. Mainly Turkish people or with Turkish background or with Russian background. Suddenly culture was an issue in discussions about health and healthcare in Germany. I found it interesting that what I knew from Ecuador, from Indigenous people, this kind of othering and cultural blaming and so on. I found now in Germany regarding migrants.

Then together with some Turkish colleagues, we started a teaching programme on this, a programme on migration health. I was kind of an outsider in this. I had my experience from Ecuador, I had my experience, it was undocumented. I was happy to learn about the Turkish perspective, the Russian, German perspective, the others that tried to synthesise and to bring things together. That was really interesting. I think there I profited is very much from the historical perspective, because I could see that to contextualise either the perspective in a certain, well historical background and social background. At the end, there was some consistent patterns that were crosscutting everything. Which was the perception of exclusion, of difficulties in access to healthcare, of inequalities. Also this problem of culture, of cultural blaming for the one hand, taking culture is very, very important, but mainly to create differences, to explain differences, and also to sustain the differences, I think. Not as a bridge, not as an invitation to communicate and to learn from each other. I hate that really. For me there, the critical point is if we can use culture for better communication between all of us. Learning from each other and understanding. Not for creating separate spheres of whatsoever and to define inequalities of privilege or use it for blaming purposes. How we are used often to do so.

In the end, I discovered of the human rights perspective and that's what's driving me now. That's inspiring me now to take the first article of the Universal Declaration of Human Rights, that all people are born equally and not free and equal and dignity and rights is such a powerful idea and sentence and so difficult to realise. So many people are opposed to this in all countries, especially those who are afraid of losing privilege, I think. For me, human rights is a strong programme against marginalisation, discrimination and so on. It's a huge challenge for all those who are in a privileged position and who are afraid and probably with reason are afraid of losing privileges. That's an interesting point and then relating to health. I'm very much convinced that the idea of equity, that we are all different, but equal dignity and rights. For me, the most powerful idea and motivation and to address this in all the places we are. In the hospitals, in policies and politics. Then when you think about this, you come to those people who are at the margins, who are marginalised, who are not enjoying this equality and dignity and rights. That's in many countries, migrants, not all migrants, but some migrants. We see now, because of the political context, I think in many regions of the world, that migration is becoming more and more dangerous. More and more related to risk for your health and wellbeing and prospects and so on. That's a political problem. That translates into health, the health impact of these politics. So, I think we have to think about the determinants of health, social capital. But I think mainly political determinants of health. So because these social

inequalities and exclusion and so on is related to political decisions. It's not a natural situation, but it can be changed. That's my motivation. That's also the link between Indigenous health and migration and health. Because these are two categories embracing part of our societies who are of higher risk of being excluded. I think we have to approach this in a creative way. Always driven by the goal to reduce inequities and suffering and to create a better world for all. I think we are now in a crucial moment in history.

DD: Well, can I ask, so looking forward into a post Covid world. Are you optimistic for improvements in migrant health, in indigenous health?

MK: Well, every crisis and we are living in a crisis situation, always embraces possibilities when we use the crisis to think through and to analyse what is happening. I think from a historical point of view, we should not look only on Covid-19 and under the current situation in the years 2020 and 2021. But maybe look back, for example, in 30, 40 years on this time now. It's not only one crisis we are talking about. A few years ago, we had the so-called migration crisis. Then we have now Covid-19. Then we have the people from Fridays for Future showing us that there is the climate crisis. The crisis of the planet, who has exhausted from their species, Homo sapiens. So, we have this three topics, for example, that are very much related to each other. We have to find a solution for all of this. We need a common ground, a unifying perspective. We cannot- not unifying and making everything the same. But what are the crosscutting issues? At the end, it's a crisis related to the extremely growing inequalities in the world. There are some people with very high privilege who have been on the sunny side of the history and there's this history of the last hundred years, or 150 years of colonialism, exploitation, industrialisation. But I think we have to come out of this and this extreme tendency to exploit the planet and the people for four short term goals. The response can only be a movement and alternative approaches that are more equitable and inclusive. The mess that we are living today is a result of this history, I think. You ask me if I'm optimistic when I'm looking on the facts on what is happening. I'm very pessimistic. But I know that people lived in times much harder than what we are living today. They did not give up and they overcame this crisis. So there's always a reason for optimism. At the same time, I'm very optimistic, because of so many young people, so many colleagues and so many committed people working in this direction. So what gives me optimism is the power of the people.

DD: Yes, we see the climate change movement is led by younger people pushing the agenda forward.

MK: We really are in a time after three, four or five decades that have been lost by those in power. We cannot lose any more time because it's really a critical phase.

DD: It's the actions of a few people. You know, looking back over the last few decades, going to the 80s, for example, a few political leaders, a few business leaders who take certain directions. The last few decades could have been very different.

MK: Absolutely. Yes. I think the main political problem that we see in this, is the lack of accountability for governments. The lack of control and the lack of participation. We need to hold accountable the governments. That's for me, one of the key aspects of human rights and multilateralism and part of the solution.

DD: So you recently started to appreciate your own family's migration story when you found out about your father, who was displaced from Eastern Germany, now, Poland. Was in the German army and then settling again post war and building a life in Germany. Can you tell us how you found out and what effect this has had on you and how you how you perceive migration?

MK: Yes, it was one of these very special moments in life. I knew only little about my father's life as a young boy and his family. I knew that he was raised in Upper Silesia, which was part of the German Reich at that time and know Southern Poland. That he went to war aged 14, 15, at the end of the Second World War. Then I knew that his parents went to West Germany and that knew that he was working after the war in the construction industry. I had the idea that he did the kind of professional formation or education and the construction. Then he went to university to become an engineer, a civil engineer and so on, and everything smooth. Then my aunt, now aged 93, sent me, to my brother's a letter she found from 1948 where he explains his situation. Now, finally, at the university, no longer doing this terrible unskilled labour in the construction industry. He had finally the possibility for educating himself. They had finally stabilised the situation after arriving to Germany as displaced peoples. The future was so unclear. This letter of my father, I found this idea of finally starting to live, kind of flourishing. This letter shows this idea of security and future after a forced displacement situation. That reminds me very much of what I see now when I work on migration and health. What I saw from people fleeing Syria and trying to make their living. We cannot cure all the trauma time. But what we can do is create stability, security and a sense of belonging in a new place. That, for me is one of the biggest scandals and injustices in the world today. I like very much this

this slogan from the SDGs, "No one is left behind." No one must be left behind. I really would wish that the community and all people take seriously this simple third sentence. No one must be left behind. That for me is the programme for building our global society into a better future. Absolutely.

DD: Thank you. So Michael, thank you for joining me today. I always like speaking to you. Using an anthropological approach and learning from history is crucial. So many atrocities have been committed against Indigenous people and also against migrants. We have no hope of moving forward to improve health without taking on board these historical perspectives and people's own understanding. Thank you for joining me.

MK: Thank you Delan. It was a pleasure.

DD: Thank you to my guest, Michael Knipper. The episode was produced by Sruthi Mahadevan and myself. The theme song is Paper Stars by Liam Aidan. This is a Global Health Lives podcast. Thank you for listening.