Review of International Studies (2021), **47**: 4, 422–442
doi:10.1017/S0260210521000346

RIS

RESEARCH ARTICLE

The power-trust cycle in global health: Trust as belonging in relations of dependency

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(Received 11 December 2019; revised 15 February 2021; accepted 17 May 2021; first published online 8 July 2021)

Abstract
Trust between actors is vital to delivering positive health outcomes, while relationships of power determine health agendas, whose voices are heard and who benefits from global health initiatives. However, the relationship between trust and power has been neglected in the literatures on both international politics and global health. We examine this relationship through a study of relations between faith based organisations (FBO) and donors in Malawi and Zambia, drawing on 66 key informant interviews with actors central to delivering health care. From these two cases we develop an understanding of 'trust as belonging', which we define as the exercise of discretion accompanied by the expression of shared identities. Trust as belonging interacts with power in what we term the 'power-trust cycle', in which various forms of power undergird trust, and trust augments these forms of power. The power-trust cycle has a critical bearing on global health outcomes, affecting the space within which both local and international actors jockey to influence the ideologies that underpin global health, and the distribution of crucial resources. We illustrate how the power-trust cycle can work in both positive and negative ways to affect possible cooperation, with significant implications for collective responses to global health challenges.

Keywords: Global Health; Health Diplomacy; Power; Trust; Dependency; Africa; Malawi; Zambia

Introduction

This article investigates the power-trust relations between actors central to delivering health in Africa: donors and local faith-based organisations (FBOs). Understanding these relations is crucial to global health where weak African health systems face severe resource limitations, the world's greatest health challenges, and there is enduring public distrust.[1] Many African states rely on development assistance for health (DAH), FBO health providers fill vast gaps in state capacities, and the West's history of scientific exploitation contributes to continued scepticism about donor intentions.[2] This article is based on several years of fieldwork in Zambia and Malawi, and although we did not start our inquiries intending to focus on trust, trust and the complex ways it intertwines with power emerged from our interviews as fundamental to health diplomacy and health outcomes. And yet, analysis of power-trust relations is neglected in the IR and global health literatures.

[1]Amy Patterson, *Africa and Global Health Governance* (Baltimore, MD: Johns Hopkins University Press, 2018); Paul Richards, Esther Mokuwa, Pleun Welmers, Harro Maat, and Ulrike Beisel, 'Trust, and distrust, of Ebola Treatment Centers', *PloS One*, 14:12 (2019), e022451.

[2]Johanna Crane, *Scrambling for Africa: AIDS, Expertise and the Rise of American Health Science* (Ithaca, NY: Cornell University Press, 2013); Melissa Graboyes, *The Experiment Must Continue* (Athens, OH: Ohio University, 2015).

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https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

This article makes three contributions. First, bringing multifaceted power relations to the study of trust in IR problematises the established relationships between uncertainty, vulnerability, and trust. The trust literature has not engaged fully with the question of power, often conceptualising trust and power as 'functional equivalents'[3] and using trust to push back against purely power-based accounts of international politics. Highly asymmetric power relations such as those between donors and aid recipients have fallen outside of trust explorations in IR, and yet these types of relations and actors are part of the conduct of international politics and are central to global health. Rather than deciding that such actors are outside the study of trust because of their dependency, we advance existing research by examining how trust interacts with power in such circumstances. Our analysis of FBO-donor relations in health diplomacy enables us to conceptualise a trust in international politics that extends beyond the interstate and conditions of anarchy to account for actors of objectively unequal power and expose how trust interacts with power. We develop the concept of 'trust as belonging', which we define as the exercise of discretion accompanied by the expression of shared identities. Attention to FBOs – institutions that emphasise a spiritual mission and 'otherworldly calling' – allows us to highlight the deep foundations for belonging.

Second, we contribute to the literature debating the various forms of power in global health[4] through understanding how power interacts with trust. We know that power and trust matter for health diplomacy since they shape collaborative relationships, policy development, and health outcomes. James Pfeiffer highlights that when trust breaks down (or was never established), projects tend to fail. He draws attention to how trust has *implications for power*, since it may prevent abuses that advantage some over others, generate more equitable access to resources, and give dependent states and actors greater sovereign control over health initiatives.[5] By examining African non-state actors that are not typically considered to be powerful but are nevertheless crucial in political change and development,[6] we augment knowledge on health diplomacy, a field that foregrounds a plethora of new actors working at multiple levels from interstate negotiations to multistakeholder, national diplomacy.[7] We focus on FBOs as one type of non-state actor, because they provide half of health care services in some African countries, and they receive millions of dollars in DAH annually.[8] Donors also tend to view FBOs as relatively trustworthy actors,[9] making them a crucial avenue through which to understand the confluence of power and trust. Through our analysis we develop the 'power-trust cycle' to account for how various forms of power undergird the vulnerabilities and competencies that matter for trust and how trust can, in turn, augment various forms of power.

[3]Guido Möllering, 'Connecting trust and power', *Journal of Trust Research*, 9:1 (2019), pp. 1–5 (p. 1); see Reinhard Bachmann, 'Trust, power and control in trans-organizational relations', *Organization Studies*, 22:2 (2001), pp. 337–65; Lucy Gilson, 'Trust and the development of health care as a social institution', *Social Science and Medicine*, 56 (2003), pp. 1453–68.

[4]Suerie Moon, 'Power in global governance', *Global Health*, 15:74 (2019), p. 6; Veena Sriram, Stephanie M. Topp, Marta Schaaf, Arima Mishra, Walter Flores, Subramania Raju Rajasulochana, and Kerry Scott, '10 best resources on power in health policy and systems in low- and middle-income countries', *Health Policy and Planning*, 33 (2018), pp. 611–21; Jeremy Shiffman, 'Knowledge, moral claims and the exercise of power in global health', *International Journal of Health Policy and Management*, 3:6 (2014), pp. 297–9.

[5]James Pfeiffer, 'International NGOs and primary health care in Mozambique', *Social Science & Medicine*, 56:4 (2003), pp. 725–38 (pp. 735–6).

[6]Emma-Louise Anderson and Amy Patterson, *Dependent Agency in the Global Health Regime* (Basingstoke, UK: Palgrave MacMillan, 2016); Jennifer Clapp, 'Africa, NGOs, and the international toxic waste trade', *Journal of Environment and Development*, 3:2 (1994), pp. 17–46.

[7]Rebecca Katz, Sarah Kornblet, Grace Arnold, Eric Lief, and Julie Fischer, 'Defining health diplomacy', *Milbank Quarterly*, 89:3 (2011), pp. 503–23; Iona Kickbusch, Gaudenz Silberschmidt, and Paulo Buss, *Global Health Diplomacy* (Geneva: WHO, 2008); Ilona Kickbusch and Mihály Kökény, 'Global health diplomacy', *Bulletin of the WHO*, 91:3 (2013), p. 159.

[8]Alyson Lipsky, 'Evaluating the strength of faith', *Public Administration and Development*, 31:1 (2011), pp. 25–36.

[9]Amy Patterson, *The Church and AIDS in Africa* (Boulder, CO: First Forum Press, 2011).

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

Finally, we move beyond analysis of asymmetrical donor-local relations based on donor control of development assistance to recognise how donors and local actors simultaneously possess multiple, interconnected forms of power.[10] Here we understand power as 'the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate'.[11] This has significance for debates in international development about state capacity and institution building[12] because it enables us to better account for the ways that donors extend their power and how local actors – often perceived as weak or powerless – exert influence.[13] We find local actors make use of institutional, epistemic, and normative power to leverage trust and, in turn, leverage trust to offset and mediate the structures of dependency.

The article is set out as follows. Section one develops our conceptualisation of trust as belonging to account for trust in relations of dependency. Section two explains the elements of power that are manifest in donor-local relations in health diplomacy. Section three details our methods. Section four analyses trust as belonging in FBO-donor relations and demonstrates how power undergirds trust and trust augments power in a power-trust cycle. The article concludes by challenging global health actors to recognise the consequences of the power-trust cycle, and highlighting the potential for its transformation through donor-local efforts to nurture trust as belonging.

Trust as belonging in relations of dependency

The majority of IR trust literature assumes that the international realm has unique barriers to trust because of the condition of anarchy and the ensuing security imperatives placed on states.[14] Ken Booth and Nicholas Wheeler pose a question that sums up much of the existing research: 'How can actors learn to trust each other – should they? – in a condition of anarchy?'[15] This question binds the study of trust to a set of international actors (notably the state) that, at least in theory, make decisions as more-or-less equal agents in a context of anarchy.[16] While the literature does not ignore power asymmetries between states, the role of institutions, or the links between trust and interdependence,[17] it views dependency as the *outcome* of trust,[18] as state actors make 'wilful decisions' to trust or distrust.[19] The IR literature thus ignores the potential for trust within relations of dependency. This establishes a set of relations and contexts for trust in international politics that has several impacts. Firstly, it encourages a focus on interstate relations. Even research grounded in social or cognitive psychology, for example, explains the tendency to trust as 'anarchical social capital'.[20]

[10]Michael Barnett and Raymond Duvall, 'Power in international politics', *International Organization*, 59:1 (2005), pp. 39–75 (p. 41).

[11]Ibid., p. 42.

[12]Matt Andrews, Lant Pritchett, and Michael Woolcock, *Building State Capability* (London, UK: Oxford University Press, 2017), p. 288.

[13]Radhika Gore and Richard Parker, 'Analysing power and politics in health policies and systems', *Global Public Health*, 14 (2019), pp. 481–8; James Scott, *Weapons of the Weak* (New Haven, CT: Yale University Press, 1985).

[14]Exceptions include Torsten Michel, 'Time to get emotional', *European Journal of International Relations*, 19:4 (2012), pp. 869–90; Karen Fierke, 'Terrorism and trust in Northern Ireland', *Critical Studies on Terrorism*, 2:3 (2009), pp. 497–51; Laura Considine, 'Back to the rough ground!' A grammatical approach to trust and international relations', *Millennium*, 40:4 (2015), pp. 109–27.

[15]Ken Booth and Nicholas Wheeler, *The Security Dilemma* (Basingstoke, UK: Palgrave Macmillan, 2008), p. 231. See also Vincent Keating and Jan Ruzicka, 'Trusting relationships in international politics', *Review of International Studies*, 40:4 (2014), p. 755; Brian Rathbun, *Trust in International Cooperation* (Cambridge, UK: Cambridge University Press, 2012), p. 6.

[16]Michel, 'Time to get emotional', p. 884.

[17]Brian Rathbun, 'It takes all types: Social psychology, trust, and the international relations paradigm in our minds', *International Theory*, 1:3 (2009), pp. 345–80.

[18]Niklas Luhman, *Trust and Power* (New York, NY: John Wiley and Sons, 1979).

[19]Torsten Michel, 'Trust, rationality and vulnerability in international relations', in Amanda Beattie and Kate Schick (eds), *The Vulnerable Subject* (London, UK: Palgrave Macmillan, 2013), pp. 86–109 (p. 98).

[20]Brian Rathbun, 'Before hegemony: Generalized trust and the creation and design of international security organizations', *International Organization*, 65:2 (2011), pp. 243–73.

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Secondly, the anarchy problematic reproduces particular meanings and relationships for core elements of trust: uncertainty and vulnerability.[21] Anarchy 'magnifies the impact of uncertainty about the motives of others' and implicitly limits it to uncertainty about state actions.[22] For example, rational choice accounts of trust explain uncertainty in terms of distinguishing between status quo and revisionist states.[23] Others understand uncertainty as discerning the peaceful intentions of states,[24] or through the dynamics of the security dilemma.[25] Similarly, the literature emphasises that anarchy compounds the vulnerability that comes with trusting under circumstances of uncertainty. Work on trusting relationships argues that such relationships require either the willing acceptance of vulnerability,[26] or a lack of felt awareness of vulnerability and thus a lack of hedging behaviour.[27] This position assumes a level of capacity either to accept vulnerability or hedge against it, as well as a specific understanding of the nature of vulnerability, which is not always appropriate once one moves outside the interstate level. For example, local health providers in Malawi experience multiple acute vulnerabilities and may lack any hedging capacity. Vulnerability is not always something such actors can choose to accept or ignore. We either can decide that these actors are outside the study of trust in IR, or we can supplement current research with work that examines what trust means in these contexts. Existing conceptions of the trust-uncertainty-vulnerability dynamic do not allow for studying trust in highly asymmetric power relations and therefore do not unpack questions of power, instead understanding relations of power/dominance as alternatives to relations of trust in the facilitation of cooperation.[28]

The assumption of anarchy and its effects on vulnerability and uncertainty remain constant across both strategic and moral approaches to trust.[29] Strategic trust assumes actors decide to trust based on information that one party has about another being potentially trustworthy (that is, cooperative). Potentially trusting actors are rational egoists reacting to varying incentives to cooperate in situations of uncertainty.[30] Work that has contested the strategic approach argues that trust involves not just the expectation of a potential trustee's cooperative preferences or behaviour but also that any cooperation is based on a conviction of the benevolence of the trustee, not just incentive/assurance structures. Trust requires a 'human factor'[31] and a conviction that the other will 'do what is right'.[32] This literature roots trust in conditions that include emotions, personal ties, generalised expectations of moral behaviour, common identities, or interpersonal interactions.[33]

[21]Booth and Wheeler, *The Security Dilemma*.

[22]Jan Ruzicka and Vincent Keating, 'Going global: Trust research and international relations', *Journal of Trust Research*, 5 (2015), p. 3.

[23]Andrew Kydd, 'Trust building, trust breaking', *International Organization*, 55:4 (2001), p. 810.

[24]Nicholas Wheeler, 'Beyond Waltz's nuclear world: More trust may be better', *International Relations*, 23:3 (2009), pp. 428–45.

[25]Booth and Wheeler, *The Security Dilemma*; Andrew Kydd, *Trust and Mistrust in International Relations* (Princeton, NJ: Princeton University Press, 2005); Nicholas Wheeler, 'Investigating diplomatic transformations', *International Affairs*, 89:2 (2013), pp. 477–96.

[26]Aaron Hoffman, 'A conceptualization of trust in international relations', *European Journal of International Relations*, 8:3 (2002), pp. 375–401.

[27]Vincent Keating and Jan Ruzicka, 'Trusting relationships in international politics', *Review of International Studies*, 40:4 (2014), pp. 753–70.

[28]Cynthia Hardy, Nelson Phillips, and Thomas Lawrence, 'Distinguishing trust and power in inter-organizational relations', in Christel Lane and Reinhard Bachmann (eds), *Trust Within and Between Organizations* (Oxford, UK: Oxford University Press, 1998), pp. 64–87; Bachmann, 'Trust, power and control'.

[29]Michel, 'Time to get emotional'.

[30]Kydd, *Trust and Mistrust*; Andrew Kydd, 'Trust, reassurance, and cooperation', *International Organization*, 54:2 (2002), pp. 325–57.

[31]Booth and Wheeler, *The Security Dilemma*.

[32]Hoffman, 'A conceptualization of trust', p. 381.

[33]See Bernd Lahno, 'On the emotional character of trust', *Ethical Theory and Moral Practice*, 4:2 (2001), pp. 171–89; Nicholas Wheeler, *Trusting Enemies* (Oxford, UK: Oxford University Press, 2018); Jonathan Mercer, 'Rationality and

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We conceptualise trust in two parts. The first is the 'exercise of [discretion] by some agent (individual or artificial) on behalf of another over matters that the trusting agent cares about'.[34] The focus on the exercise of discretion places trust in the act of trusting rather than in the belief that the other is trustworthy. This view understands trust as 'the generic name for habitual practices in which processes of long-term cooperation are embedded in world politics' in which players do not always consciously decide to trust.[35] Understanding trust as a practice that can exist alongside other practices does not place trust and power in opposition to each other but allows them to be at work in the same contexts. It also avoids assuming a certain type of formally independent international trusting actor, unlike definitions that rely on accepting/ignoring vulnerability.

Our second element is trust as identification, which builds on Aaron Hoffman's work on 'fiduciary' trust that points out how discretion alone is not enough for trust, because exercise of discretion could simply be a calculative act of risk taking.[36] Trust also needs to include a 'relational and affective element'[37] outlined by moral/emotional accounts of trust, so that it 'involves risk, but cannot be reduced to risk'.[38] This relational element is evident in trust as identification, or a trust that is founded on an emotional identification with other members of a perceived in-group.[39] When individuals share values, experiences, and common goals, they view one another as familiar and create ties of reciprocity.[40] Shared identities lead to the construction of common expectations about obligations and similar views on grievances,[41] all of which provide the grounding for trust. In our conceptualisation of trust, the granting of discretion is accompanied by 'shared values, perceived similarities, sympathy and a common vision'.[42] Such trust is not merely rooted in rational trust linked to calculation, but it also identifies one's needs and self with the other. We term this two-sided view of trust as 'trust as belonging'.

Our claim is that trust as belonging, understood as the exercise of discretion accompanied by the expression of shared identities, can be understood as a practice that is embedded in the relationships under study alongside complex relations of power. This provides a long-term view of trust developed as the 'product of particular identity relationships that develop over time'.[43] Actors identify commonalities, engage at the interpersonal level (such as through face-to-face meetings), and empathetically 'put oneself into the other fellow's place'.[44] Donors and local actors may share core values and goals (such as the provision of healthcare services) or identities (such as religious convictions), despite the diversity of power they possess. In addition, they may share common norms and values about the ways the world should work and their role in achieving that vision, with such norms and values promoted by donors and international NGOs. Trust as belonging is part of the ongoing practices and habits embedded into relationships and interacts with the forms of power that are also at play.

psychology in international relations', *International Organization*, 59:1 (2005), pp. 77–106; Michel, 'Trust, rationality and vulnerability'; Eric Uslaner, *The Moral Foundations of Trust* (Cambridge, UK: Cambridge University Press, 2002).

[34]Nicholas Rengger, 'The ethics of trust in world politics', *International Affairs*, 73:3 (1997), p. 472. Rengger develops this definition from Annette Baier. Rengger uses 'discretionary power', which we amend here to avoid confusion with our uses of power.

[35]Ibid., p. 472; Michel, 'Trust, rationality and vulnerability', p. 93.

[36]Hoffman, 'A conceptualization of trust'.

[37]Clara Weinhardt, 'Relational trust in international cooperation', *Journal of Trust Research*, 5:1 (2015), p. 32.

[38]Hoffman, 'A conceptualization of trust', p. 384.

[39]Mercer, 'Rationality and psychology'; Uslaner, *The Moral Foundations of Trust;* J. David Lewis and Andrew Weigert, 'Trust as a social reality', *Social Forces*, 63 (1985), pp. 967–85.

[40]Robert F. Hurley, *Decision to Trust* (San Francisco, CA: Jossey-Bass, 2011), p. 57.

[41]Dorothea Hillhorst, *The Real World of NGOs* (London, UK: ZED, 2003), p. 31.

[42]Weinhardt, 'Relational trust', p. 32.

[43]Ibid., p. 34.

[44]Nicholas Wheeler, 'To put oneself into the other fellow's place', *International Relations*, 22:1 (2008), pp. 493–509; also Wheeler, *Trusting Enemies.*

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Developing an account of trust in IR that engages with dependency and multiple forms of power allows us to examine how actors have different and shifting types of uncertainty and vulnerability and how these are ameliorated or compounded by the power relations in which actors are embedded. It enables us to question how trust as belonging informs, trumps, or is superseded by forms of power. As Nicholas Rengger asserts, 'the exercise of trust can alter power positions' so the 'exercise of trust' in contexts of large power imbalances and situations of dependency is important in global politics.[45]

Forms of power in donor-local relations in health

The exercise of power is central to health systems and health diplomacy; it shapes resource distribution, policies and practices, issue prioritisation, possibilities for transformation, and ultimately, health outcomes.[46] Health system performance results from the interplay between 'hardware' (finance, technologies, and human resources) and 'software' (ideas, interests, values, power, and norms),[47] and power relations and social processes shape these interactions at the local, national, and global levels.[48] Using Suerie Moon's 2019 taxonomy of power in global health, this section introduces the forms of power at play in the donor-FBO relationships we examine. These forms of power 'can mutually reinforce tremendous power disparities in global health', but power is neither immutable nor divorced from trust.[49]

The most visible form of power in donor-local relations is compulsory power, which enables donors to compel local actors to act.[50] This power specifically derives from the economic power that donors have through the development assistance for Health (DAH) they provide.[51] However, this is not straightforward domination. Even where local actors such as the FBOs examined here depend significantly on donors for financial support, dependency is a two-way street whereby donors also rely on local actors to deliver health outcomes.[52] Locals may enact compliance to gain material resources,[53] performing identification with economically powerful partners. We recognise that at times, compulsory power (and resulting performances of compliance) may be entangled with trust as identification in an indecipherable knot.[54]

A more 'insidious' form of power that shapes the extent of donor influence in health diplomacy is structural power (the power to 'structure subjects' capacities').[55] Both structural and productive power (see below) are in no one's hands – instead the global economy works to the advantage of structurally empowered actors (donors) and to the disadvantage of the weaker, local actors. Actors do not necessarily recognise domination and can act in ways that reproduce it.[56] Donors harness structural power through their positions in institutions (that is, institutional power), whereby they exert indirect control over local actors from a distance through formal or

[45]Rengger, 'The ethics of trust', p. 481.

[46]Sriram et al., '10 best resources on power', p. 612; David McCoy and Guddi Singh, 'A spanner in the works? Anti-politics in global health policy', *International Journal of Health Policy and Management*, 3:3 (2015), pp. 151–3.

[47]Kabir Sheikh, Lucy Gilson, Irene Akua Agyepong, Kara Hanson, Freddie Ssengooba, and Sara Bennett, 'Building the field of health policy and systems research', *PLoS Med*, 8:8 (2011), e1001073.

[48]Pfeiffer, 'International NGOs and primary health care', p. 735; Craig Janes, and Kitty Corbett, 'Anthropology and global health', *Annual Review of Anthropology*, 38 (2009), pp. 167–83; Katerini Storeng, and Arima Mishra, 'Politics and practices of global health', *Global Public Health*, 9:8 (2014), pp. 858–64; James Pfeiffer and Mimi Nichter, 'What can critical medical anthropology contribute to global health?', *Medical Anthropology Quarterly*, 22:4 (2008), pp. 410–15.

[49]Moon, 'Power in global governance', p. 8.

[50]Barnett and Duvall, 'Power in international politics'.

[51]See Rita Jalali, 'Financing empowerment?', *Sociology Compass*, 7:1 (2013), pp. 55–73.

[52]Stephen Ellis, *Season of Rains* (Chicago, IL: University of Chicago Press, 2011), pp. 6, 33.

[53]James Scott, *Domination and the Arts of Resistance* (New Haven, CT: Yale University Press, 1990), p. 9.

[54]Ibid.; Anderson and Patterson, *Dependent Agency*.

[55]Barnett and Duvall, 'Power in international politics', p. 43.

[56]Stephen Lukes, *Power: A Radical View* (London, UK: Macmillan, 1974), p. 24; Barnett and Duvall, 'Power in international politics', pp. 55–6.

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informal rules.[57] At the global level, for example, donors dominate the World Bank where votes are proportional to a member-state's budgetary contributions.[58] At the national level, they use health policy processes and structures and embed their external technical advisors within government health ministries.[59] In these ways, they not only exercise economic power, but also perpetuate a productive power rooted in ideas, beliefs, and discourses.[60] Yet even within such structural constraints, scholars illustrate how informal networks, common ways of perceiving, and shared identities may enable manoeuvring and discretion, giving those with limited structural or economic power a voice.[61]

Productive power relies on 'systems of knowledge and discursive practices to provide the meanings, norms, values and identities that not only constrain actors, but also constitute them'.[62] Thus, productive power may provide opportunities for incorporation and inclusion.[63] There are three forms of unseen and unrecognised productive power that are particularly suited for entanglement with trust as identification, because they rely on shared meanings, norms, values, and identities to function.[64] The first is discursive power, which contributes to shared practices and worldviews. Discursive power operates through neoliberalism in the sense that it is a deeply embedded, hegemonic idea – a 'deep core' – that conditions debates, shrinks 'policy space', and 'colonize[s]' global health paradigms.[65] Neoliberalism refers to the emergence of new 'arts of government' developed in the Global North – notably a 'technical reliance on market mechanisms, valorization of "private enterprise" and a suspicion of the state'.[66] This neoliberal discursive power limits the realm of activities to those focused on technical efficiency, financial accountability, results, and market-driven solutions. Dominant modes of operation ('communities of practice') emerge, become entrenched, and are unquestioningly replicated[67] through report writing, development jargon, and 'best practices' across multiple contexts.[68] Although it appears that donors wield discursive power over locals in that they 'shape the language others use to conceptualize, frame, and thereby define and understand' in accordance with neoliberalism,[69] the picture is more complicated. Neoliberalism can take on new life in African contexts:[70] local actors can perform compliance with these practices (even though it may seem that they just 'mindlessly enact received scripts')[71] and leverage discourses,[72] all the while laying the foundation for trust as identification.

[57]Moon, 'Power in global governance', p. 6; Kent Buse and Sarah Hawkes, 'Health post 2015', *Lancet*, 383 (2014), pp. 678–9.

[58]Moon, 'Power in global governance', p. 6.

[59]Emma-Louise Anderson, 'African health diplomacy', *International Relations*, 32:2 (2018), pp. 194–217; Graham Harrison, 'Post-conditionality politics and administrative reform', *Development and Change*, 32:4 (2001), pp. 657–79.

[60]Martin Carstensen and Vivien Schmidt, 'Power through, over and in ideas', *Journal of European Public Policy*, 23:3 (2016), pp. 318–37 (pp. 320–1).

[61]Eduard Grebe, 'The Treatment Action Campaign's struggle for AIDS treatment in South Africa', *Journal of Southern African Studies*, 37:4 (2011), pp. 849–68.

[62]Rita Abrahamsen, 'The power of partnerships in global governance', *Third World Quarterly*, 25:8 (2004), pp. 1453–67 (p. 1459).

[63]Ibid., p. 1462.

[64]Barnett and Duvall, 'Power in international politics', p. 55.

[65]Simon Rushton and Owain Williams, 'Frames, paradigms and power', *Global Society*, 26:2 (2012), pp. 147–67; Lisa Forman, 'The ghost is the machine', *International Journal of Health Policy and Management*, 5:3 (2015), pp. 197–9.

[66]James Ferguson, 'The uses of neoliberalism', *Antipode*, 41 (2010), pp. 166–84 (p. 173).

[67]Séverine Autesserre, *Peaceland* (Cambridge, UK: Cambridge University Press, 2014).

[68]Arturo Escobar, *Encountering Development* (Princeton, NJ: Princeton University Press, 1995); Andrea Cornwall and Karen Brock, 'What do buzzwords do for development policy?', *Third World Quarterly*, 26:7 (2005), pp. 1043–60.

[69]Moon, 'Power in global governance', p. 6.

[70]Ferguson, 'The uses of neoliberalism', p. 173.

[71]John Meyer, John Boli, George Thomas, and Francisco Ramirez, 'World society and the nation-state', *American Journal of Sociology*, 103:1 (1997), pp. 144–81.

[72]Anderson, 'Shadow diplomacy'; Anderson and Patterson, *Dependent Agency*; Jeremy Shiffman, 'Agency, structure and the power of global health networks', *International Journal of Health Policy and Management*, 7:10 (2018), pp. 79–84; Scott, *Weapons of the Weak*.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

For FBOs, religious worldview forms an additional layer of discourse alongside neoliberalism. As Erica Bornstein illustrates, religious belief is a powerful undertone, one that 'inform[s] the ways that development projects are received, interpreted and accepted in specific societal and historical contexts … and the way that development is planned, conceptualized, motivated and instituted'.[73] FBOs often emphasise service provision as a means to 'witness their faith, fulfil religious teachings … or "do good" for others in the community', although the ways that their religious beliefs intersect with secularism vary significantly with the organisation and its staff.[74] Part of the religious discourse revolves around the ways that 'spiritual belief offers access to an alternative form of power'.[75]

Second, epistemic power comes from 'shaping what others consider to be legitimate knowledge' and claims of expertise,[76] with a network of experts sharing common values, epistemologies, methodologies, and practices.[77] However, global health's interdisciplinary and multidisciplinary nature, lack of common epistemology, and colonisation by non-health experts like economists may undermine this power.[78] Counter-epistemic communities may challenge biomedical 'expertise', as occurred in South Africa around AIDS and antiretroviral medications, with a counter epistemic power influencing policies that delayed treatment rollout and ultimately, cost lives.[79] Additionally, because the boundaries of relevant knowledge in global health are porous, actors may have epistemic power because of localised, contextual knowledge.

Third, normative power is 'when an actor shapes the principles that others believe to be right or wrong, and the actions that may then follow'.[80] It emerges from standing for ethical principles, claiming to serve as a community 'conscience', and at times, challenging other powers that distort justice, equity, and access. As the power of what 'ought to be', normative power may be rooted in religious or ethical beliefs or in the participation of those it affects.[81] In Africa, where many people claim high levels of religiosity, FBOs may embody this power.[82] Unlike discursive power (which is systemic), normative power involves direct claims making based on principles ('naming and shaming'), with such claims-making being a tool to achieve policy outcomes.[83] Christian FBOs, for example, may point to Christ's admonition to 'do for the least of these' when asserting the 'rightness' of their position. Because Christ's words are foundational to the faith, they evoke shared understandings that can promote trust as identification.

Finally, existing work on global health governance recognises trust as a foundation for one aspect of power – network power – which 'is wielded when individuals use their personal relationships with others to shape their thinking and/or action. Such relationships may be built on trust, reciprocity, repeated interactions over many years, shared experiences, shared identities,

[73]Erica Bornstein, *The Spirit of Development* (Stanford, CA: Stanford University Press, 2005), p. 2.

[74]Ram Canaan, *The Newer Deal* (New York, NY: Columbia University Press, 1999), p. 300.

[75]Stephen Ellis and Gerrie Ter Haar, 'Religion and politics in sub-Saharan Africa', *Journal of Modern African Studies*, 36:2 (1998), pp. 175–201 (p. 195).

[76]Moon, 'Power in global governance', p. 6; Shiffman, 'Knowledge, moral claims and the exercise of power'; Kelley Lee, 'Revealing power in truth', *International Journal of Health Policy and Management*, 4:4 (2015), pp. 257–9.

[77]Peter Haas, 'Epistemic communities and international policy coordination', *International Organization*, 46:1 (1992), pp. 1–36.

[78]Karen Grépin, 'Power and priorities', *International Journal of Health Policy and Management*, 4:5 (2015), pp. 321–2; Simon Rushton, 'The politics of researching global health politics', *International Health Policy and Management*, 4:5 (2015), pp. 311–14.

[79]Jeremy Youde, *AIDS, South Africa, and the Politics of Knowledge* (London, UK: Routledge, 2016).

[80]Moon, 'Power in global governance', p. 6.

[81]Rushton, 'The politics of researching'.

[82]Patterson, *Church and AIDS in Africa*; Jeffrey Haynes, *Religion and Development* (Basingstoke, UK: Springer, 2007).

[83]Shiffman, 'Knowledge, moral claims and the exercise of power'.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

or other factors'.[84] Network power can translate into other forms of power (economic, institutional, epistemic, or discursive).[85]

Methodology

We employ a two-level definition of trust. At its most basic, trust focuses on discretionary actions, meaning that donors' trust of locals could include giving funds to those partners and putting them in control of their projects, ultimately placing both their material interests and their reputation into the partners' hands. In turn, locals' trust of donors is apparent when locals play by donors' rules, giving donors discretion over outcomes. Yet, because we view trust to include identification, we also operationalise trust as evidenced in shared expressions of meanings, worldviews, values, and empathy expressed for the other.

We utilise a comparative case study of the Christian Health Association of Malawi (CHAM) and the Churches Health Association of Zambia (CHAZ), two FBOs that provide health care services in Malawi and Zambia, respectively. Formed in 1964, CHAM is a network of 175 health institutions (for example, clinics and hospitals) that the Catholic Church and 11 Protestant denominations operate. CHAZ, established in 1970, includes 157 health institutions run by the Catholic Church and 15 Protestant denominations. Both FBOs have professional secretariats to manage relations with member churches and donors and mobilise donor funding, and both employ nationals as public health experts in their secretariats and member health institutions.[86]

CHAZ and CHAM cannot be divorced from their country contexts. As southern African countries, Zambia and Malawi share many historical, cultural, and political experiences (for example, high poverty rates; British colonial history; Christian majority populations). In both countries, donors operate within a neoliberal transnational aid context and rely on biomedical expertise.[87] Holding these factors constant, we can point to variations that may affect the power and trust that donors and FBOs exercise. First, the countries have different levels of DAH dependency, potentially giving donors more economic power in health in Malawi than Zambia. In 2016, DAH accounted for 72 per cent of all health expenditures in Malawi (US $443 million),[88] but 34 per cent in Zambia.[89] Second, each country presents different possibilities for the FBOs' institutional power. Both FBOs are not autonomous from government, which is responsible for most of their operational costs (90 per cent for CHAM and 75 per cent for CHAZ).[90] Both FBOs have representation on multiple government institutions (see below), but unlike CHAM, CHAZ has been a principal recipient of multi-million dollar Global Fund grants since the programme began in 2002.

Our ground-up approach with respondents in Lilongwe in July 2014 and Lusaka in 2007, 2011, and 2014 allowed respondents to shape the research agenda around questions of power and

[84]Moon, 'Power in global governance', p. 6.

[85]Ibid., pp. 6–7; Pierre Bourdieu, 'The forms of capital', Mark Granovetter and Richard Swedberg (eds), *The Sociology of Economic Life* (Abingdon, UK: Routledge, 2018); Johanna Hanefeld and Gill Walt, 'Knowledge and networks', *International Journal of Health Policy and Management*, 4:2 (2015), pp. 119–21.

[86]CHAZ, 'About Us' (2018), available at: {http://www.chaz.org.zm/about-chaz}; CHAM, 'Our Impact' (2017), available at: {http://www.cham.org.mw/our-impact.html}.

[87]Susan Watkins and Ann Swidler, 'Working misunderstandings', *Population and Development Review*, 38:Suppl. (2013), pp. 197–208 (p. 199).

[88]Government of Malawi, 'Health Sector Resource Mapping', FY2017/18-2019/20 (2020), p. 15, available at: {http://www.health.gov.mw/index.php/reports?download=54:resource-mapping-round-5}.

[89]Health Policy Project, 'Health Financing Profile: Zambia' (May 2016), available at: {https://www.healthpolicyproject.com/pubs/7887/Zambia_HFP.pdf}.

[90]CHAM, 'Annual Report' (2015), p. 48, available at: {http://www.cham.org.mw/uploads/7/3/0/8/73088105/annual_report_final_2015_opt.pdf}; Christopher Simoonga and Karen Sichinga, 'Zambian Case Study: Key Lessons on PPP between CHAZ and MoH', presentation in Washington, DC (7–9 July 2015), available at: {https://slideplayer.com/slide/11775667}.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

trust.[91] We conducted semi-structured interviews with key actors: (1) country-level programme officers working with the major international donors in the health sector (for example, UK Department for International Development-DfID and US Agency for International Development-USAID); (2) technical advisors working with the Ministries of Health who have discretion over health resources; (3) officials in the Ministries of Health; (4) representatives of FBOs that provide significant health services (CHAM and CHAZ representatives, as well as officials at ecumenical church organisations like the Christian Council of Zambia); (5) major international NGOs that operate health programmes; and (6) international consultants who work with donors. We conducted 24 interviews in Malawi and 42 in Zambia. In addition, we rely on informal discussions with key actors, and informal observations at trainings or meetings we attended. Finally, we conducted documentary analysis of agreements, reports, presentations, and media stories.

We sought to establish trust between the researcher and participants in various ways. We relied on snowball sampling based on personal recommendations to gain access to officials. Because the research spanned over multiple years, authors had previously met and even interviewed several informants. In addition, one author's knowledge of the Chichewa language, and another's deep ties to Anglican, Presbyterian, and Reformed Church institutions facilitated access to and rapport with local actors. A shared status as an outsider helped to establish rapport with donor and NGO officials. We recognise how at times we too relied on trust as identification.[92] We structured interviews around broad themes, such as the actors' roles, perceptions of key health challenges, efforts to address these challenges, expectations of other actors, and expectations they face. This sequencing allowed the interviewees to determine the conversation's direction, as questions moved from issues that respondents were more comfortable discussing to those that were more sensitive.[93] We recorded most interviews (with permission) and assured respondents of the confidentiality of responses and their anonymity in publications.[94]

Trust as belonging in FBO-donor relations

This section examines the nuances of how trust as belonging – or the complex duality of trust as discretion and identification – interacts with various forms of power in the relations between FBOs and donors in Malawi and Zambia. We begin by examining how trust is exercised where donors give the FBOs discretion over two things they fundamentally care about: their resources and projects. We find that power and trust interact in a dynamic cycle that can be virtuous or vicious. We then explore the role of trust as common identification through shared neoliberal and faith-based values, examining how FBOs identify with communities and donors as knowledge brokers, and the crucial role of networks. We expose how identification underpins the power-trust cycle. Finally, we draw conclusions about the potential for the power-trust cycle to be transformed.

Discretion over resources

Resources are key to trust as the exercise of discretion in contexts where donors have considerable economic power and FBOs, significant dependency. Donors provide DAH to Malawi and Zambia and have power over whether to give or withhold (conditional) aid. The resulting volatility

[91]See Anne Mills, 'Health policy and systems research', *Health Policy and Planning*, 27:1 (2011), pp. 1–7 (p. 6).

[92]Friederike Welter and Alex Nadezhda, 'Researching trust in different cultures', in Fergus Lyon, Guido Möllering, and Mark Saunders (eds), *Handbook of Research Methods on Trust* (Cheltenham, UK: Edward Elgar Publishing, 2015), pp. 75–85 (p. 81).

[93]Mark Saunders, 'Using mixed methods', in Lyon, Möllering, and Saunders (eds), *Handbook of Research Methods on Trust*, pp. 134–44 (p. 135).

[94]The authors' home institutions provided ethical clearance.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

undermines local capacity and may mean local actors agree to what donors want, fearing that if they do not, donors will cut recipients' funding when aid budgets shrink. And yet, despite these asymmetrical power relations, trust is often present in donor-local relations.

In Zambia, donors exhibit trust by giving CHAZ discretion over significant (and increasing) amounts of funding.[95] CHAZ received its first grant from Danish Church Aid in 1992, and by 2004, it was a Global Fund principal recipient.[96] In 2012, the US government authorised CHAZ to receive funds directly as the lead agency for the PEPFAR-funded AIDSRelief project.[97] Between 2011 and 2018, donor income grew from US $25.79 million to US $33.3 million, and the organisation had maintained other income sources and annual surpluses. Its list of donors has expanded,[98] and there has been some flexibility in donor aid.[99] Most notably, as of 2019, CHAZ had received US $365 million from the Global Fund, just behind UNDP (US $385 million) and the Ministry of Health-Zambia (MoH-Z) (US $420 million).[100] CHAZ's relations with multiple donor partners limited the economic power of a single donor, though its secretariat did recognise overall dependency as a problem.[101]

In Malawi, local actors are acutely dependent and lack economic power.[102] Discretion in this case may be partial, superficial, and precarious, such that for donors a calculation of the risks of defection is still prominent. CHAM has faced major resource challenges because reports of financial mismanagement in 2010 eroded donor confidence. One key secretariat official with responsibility for the budget reflected on how this had become a 'vicious circle': 'Where we had no funding we could not attract competent people. When the donors came to the secretariat they did not find anyone who was competent and they think CHAM is not worth it [funding].'[103] Where CHAM had limited economic power, it had to be more responsive to donor requirements to improve its reputation and attract funding.[104]

CHAM's lack of economic power leads it to use extraversion: the process of strategically turning one's poverty and powerlessness into assets to gain resources and status.[105] Extraversion is a strategy that both requires a level of trust and is a request for trust. The CHAM secretariat has stressed the hopelessness of CHAM's situation, particularly in light of past financial mismanagement and poor donor relations: 'There are so many issues that are legacies of that mismanagement that are coming in the way of our partnership. I do not know if I can see through them.'[106] Like the dependency found in patron-client relations, CHAM expresses its vulnerability

[95]In 2011, 81 per cent of CHAZ's annual income came from donors and in 2018, 90 per cent. CHAZ, '2018 Annual Report' (2018), p. 36, available at: {https://www.chaz.org.zm/download/annual-report-2018/?wpdmdl=1870&refresh=5d74f70d32a4b1567946509}; CHAZ, '2011 Annual Report' (2011), p. 6, available at: {https://www.chaz.org.zm/download/annual-report-2011/?wpdmdl=822&refresh=5f0ce8d7e8fe41594681559}.

[96]'A discussion with Karen Sichinga, Executive Director of Churches Health Association of Zambia', interview published online, Berkley Center for Religion, Peace and World Affairs, Georgetown University, Washington, DC (14 February 2014), available at: {https://berkleycenter.georgetown.edu/interviews/a-discussion-with-karen-sichinga-executive-director-churches-health-association-of-zambia}.

[97]CRS and AIDSRelief, 'The AIDSRelief Zambia Partnership: Transitioning to the Churches Health Association of Zambia' (2012), available at: {https://www.crs.org/sites/default/files/tools-research/aidsrelief-zambia-partnership-transitioning-churches-health-association-zambia.pdf}.

[98]CHAZ, '2018 Annual Report', p. 36; CHAZ, '2011 Annual Report', p. 6; CHAZ, '2013 Annual Report' (2013), p. 35, available at: {https://www.chaz.org.zm/download/annual-report-2013/?wpdmdl=825&refresh=5f0cea676ab8d1594681959}.

[99]CHAZ, '2018 Annual Report', p. 11.

[100]Global Fund, 'Partner Investments', dataset (2019), available at: {https://data.theglobalfund.org/partners/ZMB}.

[101]CHAZ, 'Strategic Plan 2017–2021' (2017), available at: {https://www.chaz.org.zm/download/chaz-strategic-plan-2017-2021/?wpdmdl=805&refresh=5f0ca20d4fb531594663437}.

[102]In 2015, 97 per cent of CHAM's operating budget came from donors. CHAM, 'Annual Report' (2015), p. 547.

[103]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[104]CHAM, 'Strategic Plan 2015–2019' (2015), p. 6, available at: {http://www.cham.org.mw/uploads/7/3/0/8/73088105/cham_strategic_plan_7-2-15__1___1_.pdf}; Authors' interview with CHAM official.

[105]Jean-François Bayart, 'Africa in the world', trans. Stephen Ellis, *African Affairs*, 99:395 (2000), pp. 217–67.

[106]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

with the 'leap of faith'[107] that economically powerful donors would benevolently provide resources, exemplifying how the 'exercise of trust'[108] can change power relations.[109]

Economic power and discretion can interact as part of a virtuous power-trust cycle, as CHAZ demonstrates. As CHAZ is entrusted with greater funding, its economic power increases, which empowers it to lobby for both increases in future funding and greater discretion over how such resources can be used. On the other hand, as CHAM shows, a lack of trust can limit economic power and diminish capacity, which further erodes trust as discretion in a vicious power-trust cycle. While power-trust cycles can be mutually reinforcing, they are neither static nor immutable, but are subject to continuous contestation and renegotiation.

Discretion over projects

Trust is also present where donors give local actors discretion over the projects rolled out in their name. FBOs have considerable institutional and epistemic power that donors rely on in the realm of health. The institutional power of both FBOs is rooted in the hundreds of local churches that support them across both countries, giving them extensive reach into remote areas hard to resource and staff. A CHAM secretariat official with responsibilities for managing relations with members reflected that 'at the local level we are appreciated, particularly in remote areas' because CHAM is 'all they have known all their lives'.[110] Similarly, local partners say they trust CHAZ to look out for their interests, repeating statements like: 'They help us. They assure our voice is heard. They are our friends.'[111]

The FBOs' institutional power intertwines with epistemic power derived from expertise in health care delivery. They are organisations led by medical doctors and individuals with lengthy public health experience and both have particular expertise in delivering health care in hard-to-reach rural communities.[112] CHAM institutions provide 37 per cent of Malawi's health services and 75 per cent of services in rural areas. CHAZ affiliates provide 40 per cent of Zambia's health care and 50 per cent in rural areas. In addition, their presence in underserved areas has been long-standing, with many health centres existing from before independence and some for over one hundred years. FBO health workers live in the local communities in areas where it is hard to entice health workers to stay, with CHAM's workers, for example, being bonded to four to five years of service after their training. Thus, they are uniquely positioned to understand local needs. A CHAM representative described them as 'partners with the people'.[113] They have informal relations with local power brokers such as traditional leaders. Reflecting a common theme in all the Zambian interviews, one CHAZ official explained that long-standing community relations enabled CHAZ to understand the types of health interventions that local populations would, or would not, accept.[114]

Both FBOs extend their epistemic power by sharing their expertise. At the national level, they run health-training programmes that contribute significantly to much-needed capacity development.[115] CHAM's 12 training colleges provided the 'backbone' of training for up to 80 per cent of mid-level health professionals in Malawi in 2014. With student intake doubling in ten years, CHAM's epistemic influence is growing.[116] This track record brings some economic power

[107]Guido Möllering, *Trust: Reason, Routine, Reflexivity* (Oxford, UK: Elsevier, 2006).

[108]Rengger, 'Ethics of trust', p. 481.

[109]James Ferguson, *Global Shadows* (Durham, NC: Duke University Press, 2010).

[110]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[111]Authors' interview with Expanded Church Response official, Lusaka, 17 August 2007; Authors' interview with Christian Council of Zambia official, Lusaka, 25 February 2011.

[112]Patterson, *Church and AIDS in Africa.*

[113]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[114]Authors' interview with CHAZ official, Lusaka, 16 August 2007.

[115]Government of Malawi, 'Health Sector Strategic Plan (2011–2016)', p. 30, available at: {https://www.health.gov.mw/index.php/policies-strategies?download=14:malawi-health-sector-strategic-plan-2011-2016}.

[116]CHAM, 'Strategic Plan 2015–2019', p. 7.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

because it attracts donor support, including for scholarships.[117] CHAZ operates 11 similar training schools and conducts trainings in auditing and management for church-health institutions.[118] The donors IMA World Health and USAID have showcased the efforts of both FBOs through the Africa Christian Health Associations Platform (ACHAP).[119] CHAZ also has shared its management expertise with other African FBOs. CHAZ's ability to teach 'best practices' through 'south-south learning' deepens its epistemic power,[120] which in turn advances its institutional power.

This institutional and epistemic power provides the foundations for trust in terms of the discretion for both CHAM and CHAZ over delivering health care, which then strengthens their institutional power through their partnerships in national institutions in a virtuous cycle. Both FBOs are the major partners to the government and this facilitates resource pooling, service delivery, and specialisation along task or geographic lines.[121] Both are represented on national AIDS councils, Global Fund required Country Coordinating Mechanisms, and Ministry of Health technical working groups, yet the two differ somewhat in the depth of institutional power and the levels of trust.

In Zambia, informants say that even when CHAZ has had differences with the government (for example, about government reimbursements), they work to preserve a 'cooperative', 'positive', 'collaborative', and 'trusted partnership'.[122] CHAZ often plays along when government claims credit for its accomplishments. As one donor official said, reflecting a widespread donor sentiment in Zambia, 'Sometimes government is really proud of CHAZ and says it [CHAZ] is actually government.'[123] The relationship has enabled CHAZ to convince the MoH-Z to act on issues such as hospice care, the creation of health databases in new districts, and autonomy for church-run facilities.[124] The relationship may be aided by the larger political context, in which the national ecumenical church bodies that support CHAZ have played only a limited role in politics in the last decade.[125] The positive CHAZ-government relationship also makes it easier for donors to work with CHAZ, because they can claim to respect state sovereignty and eschew political entanglements. Hence, CHAZ has been involved with the World Bank's Performance-Based Financing group, the Country Coordinating Mechanism grant formulation and disbursement meetings, and stakeholder sessions to write the National Health Strategic Framework, and the National AIDS Strategic Framework.[126] CHAZ's institutional power enables it to benefit from discursive power as it reifies the neoliberal idea that service delivery is a technical, apolitical exercise.[127]

CHAM also has institutional power through its relationship with the government, with a key representative of the CHAM secretariat who worked closely with the government explaining that 'government points the direction and we come in to support the government to steer the ship in

[117] CHAM-CDC, 'HIV/AIDS Project 2015–2019', available at: {http://www.cham.org.mw/cham-cdc-hivaids-partnership.html}.

[118] CHAZ, '2017–2021 Strategic Plan'.

[119] Patrick Kyalo and Doris Mwarey, 'Looking Back and Encouraged to Press on for the Health Workforce in Africa' (13 April 2015), available at: {https://imaworldhealth.org/looking-back-and-encouraged-to-press-on-for-the-health-workforce-in-africa}.

[120] For a critique, see Amy Barnes, Garrett Brown, and Sophie Harman, *Global Politics of Health Reform in Africa* (Basingstoke, UK: Palgrave Macmillan, 2015); Anderson, 'African health diplomacy', pp. 199–200.

[121] Jennifer Brass, *Allies or Adversaries: NGOs and the State in Africa* (London, UK: Cambridge University Press, 2016).

[122] Authors' interviews with: NAC official, Lusaka, 12 August 2007; international donor, Lusaka, 23 February 2011; DfID official, Lusaka, 15 August 2007; US Embassy official, Lusaka, 13 August 2007; international FBO official, Lusaka, 31 March 2011; CHAZ official, Lusaka, 13 April 2009. Simoonga and Sichinga, 'Zambian Case Study'; CHAZ, '2018 Annual Report'.

[123] Authors' interview with US embassy official, Lusaka, 13 August 2007.

[124] CHAZ, '2013 Annual Report'.

[125] Amy Patterson, 'Christianity and democracy', in Gabrielle Lynch and Peter VonDoepp (eds), *The Routledge Handbook of Democratization in Africa* (London, UK: Routledge, 2019), pp. 275–87.

[126] CHAZ, 'Strategic Plan 2017–2021'.

[127] James Ferguson, *The Anti-Politics Machine* (Cambridge, UK: Cambridge University Press, 1990).

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

that direction'.[128] However, disputes between CHAM and government due to mismanagement of donor funding and the breakdown in local service level agreements have had the potential to limit CHAM's institutional power and make it harder for the donors to work with CHAM. Both the government and CHAM claimed the other had reneged on obligations in the service level agreement whereby CHAM provides services and the government reimburses those services by paying CHAM salaries.[129] This affected the operation of facilities, led to diminishing worker morale, and exacerbated 'brain drain' of workers from CHAM facilities to government facilities. In response, some CHAM facilities refused to provide services and others reintroduced user fees – both actions diminished community trust for those facilities and eroded CHAM's institutional ties to member churches.[130] A key independent negotiator in the dispute reported that 'meaningful dialogue' had broken down, primarily because of the 'trust gap' between the Ministry of Health-Malawi (MoH-M) and CHAM.[131] These tensions are set within a context in which Malawian churches have become more engaged in civil society mobilisation on good governance issues.[132] In the wake of this dispute, a CHAM secretariat official highlighted the importance of strengthening trust, working with donors and government so that they understand CHAM's role, interests, and needs, particularly its fundamental need 'to be valued and seen as relevant'. The secretariat's strategy included face-to-face interactions through participating in technical working groups where '[we should] express [our]selves without being self-serving'.[133]

Long-term relationships, institutional partnerships, and practices of knowledge transfer are foundations of trust as discretion, as donors depend on the FBOs to deliver project outcomes, something possible because of their experience and knowledge of local contexts. This dependence also deepens the FBOs' epistemic power and can position them as brokers between donors and local communities (explored below) in a virtuous cycle. However, the power-trust cycle can become vicious and we highlight the importance of understanding these complex dynamics. We now move on to consider the important role of common identification that operates alongside trust as discretion.

Neoliberal and faith-based identification

The sharing of ethical values and practices between donors and FBOs is key to trust as identification. Both FBOs relied on sharing common identities and commitments with donor audiences to promote trust, harnessing the discursive power of neoliberalism and drawing on shared faith-based identities. They differ in these efforts because of their organisations' histories: CHAM engaged in performances to build trust while CHAZ reaffirmed trust.

CHAM has emphasised its commitment to transparency by publicly acknowledging a legacy of mismanagement and contrasting past and current organisational practices. Reflecting the position set out in the 'Strategic Plan 2015–2019', one secretariat member explained how 'five years ago the secretariat had huge management issues, so we lost a lot of partnerships with financial mismanagement. International Christian and government donors were pulling out. That legacy led to a weakened position.'[134] To address this weakness, CHAM had to be responsive to donor requirements to improve its reputation and relied on DfID (through the consultancy organisation Options) for technical support in financial management and governance.[135] CHAM instituted

[128]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[129]Authors' interview with independent consultant on health and development, Lilongwe, 29 June 2014.

[130]Authors' interview with independent consultant on health and development, Lilongwe, 29 June 2014. See Chimwemwe Mangazi, 'CHAM medics to go on strike', *Capital Radio Malawi* (2 January 2015); Hanneke Pot, Bregje de Kok, and Gertrude Finyiza, 'When things fall apart', *Reproductive Health Matters*, 26:54 (2018), pp. 126–36 (p. 129).

[131]Authors' interview with independent consultant on health and development, Lilongwe, 29 June 2014.

[132]Peter VonDoepp, 'Resisting democratic backsliding', *African Studies Review*, 63:4 (2019), pp. 1–25.

[133]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[134]Ibid.; CHAM, 'Strategic Plan 2015–2019', p. 6.

[135]CHAM, 'Strategic Plan 2015–2019', p. 9.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

reforms, repaid debts, 'initiated a thorough organisational overhaul', and terminated responsible parties.[136] Its strategic plan emphasised a commitment to reposition itself as a 'modern, sustainable and efficient association' with a focus on 'management'.[137] In short, it adopted the practices and language that undergird donors' discursive power in order to be attractive to a variety of donors.[138]

CHAZ has engaged in activities that remind partners that it already is a trusted partner. It has heralded its history of transparency, made its external audits public, disclosed tenders for procurement of medical supplies, and held annual meetings with CHAZ members to gain their input on policy proposals. CHAZ had internalised the activities and jargon of neoliberalism, including a focus on 'remaining competitive', even framing its new office location as an efficient way to avoid the 'unbearable' downtown Lusaka traffic.[139] CHAZ's normative power rooted in a history of ethical behaviours deepens donors' trust. CHAZ emphasises this history:

> CHAZ has had 15 years [of] unbroken record of accomplishment as a PR [principal recipient] of the Global Fund mostly attributed to its strong governance structures and adherence to its principles of transparency and accountability … During the 2009 Global Fund OIG [Office of Inspector General] audits, CHAZ was the only PR to have passed a clean bill of health.[140]

Both CHAM and CHAZ contrasted themselves with government ministries and other NGOs that were perceived to be corrupt, incompetent, and unable to do their jobs (such as paying health workers' salaries).[141] In the wake of 'Cashgate' in Malawi in 2013, when news broke that government officials absconded with an estimated US $150 million, CHAM had the opportunity to make such contrasts. There was a 'crisis of confidence' among donors who then withheld US $150 million[142] and embedded technical advisors into the MoH-M in order to have 'eyes on the ground' to help audit DAH expenditures and to bolster technical capacity.[143] Even if donors did not fully trust CHAM, it became the least distrusted partner, as donors bypassed government and funded NGOs.[144] Similarly, 'CHAZ looked good' in 2010 when another Global Fund principal recipient – the Zambia National AIDS Network (ZNAN) – was reported to have stolen significant Global Fund monies. Donors then trusted CHAZ to take over management of ZNAN's grants.[145] Because the scandal related to channelling ZNAN funds to government officials,[146] CHAZ appeared to be a technical organisation above the dirtiness of politics, one aligned with neoliberal discourses on service delivery and religious discourses on honesty and integrity.

[136]Ibid., pp. 91, 96.

[137]Ibid., p. v.

[138]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[139]CHAZ, '2018 Annual Report', pp. 7, 9.

[140]CHAZ, '2017 Annual Report', pp. 9, 17.

[141]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[142]Norad, 'Report 4/2017 Country Evaluation Brief: Malawi', Chr. Michelsen Institute, Oslo (June 2017), p. 12, available at: {https://norad.no/globalassets/publikasjoner/publikasjoner-2017/evaluering/4.17-country-evaluation-brief_malawi.pdf}; 'Cashgate- Malawi's murky tale of shooting and corruption', *BBC News* (27 January 2014), available at: {https://www.bbc.com/news/world-africa-25912652}; Authors' interview with donor official, Lilongwe, 26 June 2014; Radha Adhikari, Jeevan Raj Sharma, Pam Smith, and Address Malata, 'Foreign aid, Cashgate and trusting relationships amongst stakeholders', *Health Policy and Planning*, 34:3 (2019), pp. 197–206 (pp. 200–02).

[143]Authors' interviews with: international donors, Lilongwe, 26 June 2014, 4 July 2014, 9 July 2014; technical advisor with MoH-M, Lilongwe, 26 June 2014; technical advisor with MoF, Lilongwe, 27 June 2014.

[144]Richard Tambulasi, 'When public services contracts are poorly managed', *International Public Management Review*, 15:1 (2014), pp. 83–99 (pp. 83–4); Adhikari et al., 'Foreign aid, Cashgate and trusting relationships'.

[145]Authors' interview with international donor, Lusaka, 23 February 2011.

[146]Anderson and Patterson, *Dependent Agency*, pp. 45–6.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

While the two organisations differed in how they portrayed themselves in light of their past experiences, both drew on religious discourses to promote shared values and identity with donors and local populations. For CHAZ, this meant emphasising its family-centred approach to health care, as the executive director wrote: 'I have no doubt that the CHAZ model of delivering health-care services that *places the family at the centre* … contributed to CHAZ's outstanding performance over the years.'[147] The Catholic concept of subsidiarity that focuses on tackling underdevelopment at the lowest level undergirds CHAZ's activities, as well as the cultural focus on the individual as part of a family unit.[148] This faith-based perspective aligned CHAZ with several international FBOs, such as World Vision, Ecumenical Pharmaceutical Network, Catholic Relief Services, and Christian Aid. Together, locals and donors shared a biblical language and spiritual motivation for engagement on health, believing that people are created in God's image and that God calls Christians to build 'heaven on earth' by meeting people's basic needs.[149] Not only does the family-based approach show CHAZ's identification with faith-based donors, but it also helps CHAZ identify with neoliberal organisations that stress civil society's creativity and the private realm.[150] For CHAM, confirming a shared identity revolved around the use of biblical imagery. In its 2015 report, CHAM compared itself to the Old Testament character of Daniel, a leader whom God rewarded for his integrity: 'As we commit this report to the CHAM family and partners, we are drawn to the image of Daniel … his enemies sought to find fault in him, but could not find any "because he was trustworthy and neither corrupt nor negligent" (Dan. 6:4).' The reference to God's reward for the honest person reminds readers of a shared foundation among local and international FBOs.[151]

Both CHAM and CHAZ emphasise that their unique spiritual calling makes them accountable to God, in contrast to the secular state. For example, at the conference of ACHAP in 2015 the CHAM Secretariat spoke of CHAM's 'Biblical mandate' in contrast to the government's 'Constitutional obligation'.[152] Donors spoke about how this commitment made them trust CHAZ's work – they were an organisation that 'walked the walk'.[153] Their executives had chosen to work for these organisations because of their Christian commitment to 'serving the poor and underprivileged'.[154] Donors illustrated a certain amount of willingness to see things through CHAZ's perspective and to search for common ground, possibly because even among secular organisations, many Zambian staff were Christian.[155]

Trust as the expression of shared identities plays a vital role in the power-trust cycle. Where local actors – such as CHAZ – are effective in harnessing the discursive power of neoliberal practices they become trusted partners to donors and this brings more discretion over resources and projects. However, crucial in the relations examined here is how FBOs draw on the normative power of shared religious and ethical beliefs, to build deeper faith-based identification, which is in turn fundamental to extending various powers.

[147]CHAZ, '2017 Annual Report', p. 7.

[148]See Katharina Hofer, 'The role of evangelical NGOs in international development', *Afrika Spectrum*, 38:3 (2003), pp. 375–98.

[149]Authors' interview with international FBO official, Lusaka, 21 May 2011.

[150]Authors' interview with CHAZ official, Lusaka, 16 August 2007.

[151]CHAM, 'Annual Report', p. 48.

[152]Mwai Makoka, 'Strengthening PPPs and Interfaith Partnerships for UHC', presentation at ACHAP 7th Biennial Conference, Nairobi (25 February 2015), available at: {https://www.slideshare.net/achapkenya/malawi-experience-by-dr-makoka-cham}; CHAM, 'Strategic Plan 2015–2019', pp. xv, 5.

[153]Authors' interviews with: US PEPFAR program official, Lusaka, 13 August 2007; international FBO official, Lusaka, 17 March 2011.

[154]'A discussion with Karen Sichinga', interview available online.

[155]Authors' interview with World Vision official, Lusaka, 15 August 2007; authors' observation, donor meeting, Lusaka, 11 February 2011.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

Dual identification as knowledge brokers

Trust as identification also emerged as the two organisations translated knowledge between epistemic and counter-epistemic communities. As 'knowledge brokers'[156] navigating between biomedical (secular) approaches and holistic (spiritual) approaches to health, these FBOs cultivated trust with donors through a shared identity as practitioners of modern medicine and with locals through a shared cultural and religious identity. They reflected the epistemic power of biomedical expertise in their physicians and nurses, their evidence-based approaches, and their lengthy health care experience, all of which donors respected.[157] But the two organisations also recognise that many of the people they serve view health holistically to include spiritual elements. Thus, they translate biomedical knowledge into arenas that locals understand and they support prayer and reading scripture as part of care.[158] One CHAZ physician explained what she told clients when they wanted to rely solely on prayer, not AIDS medications, for healing, 'God gives us the medicine and His power is within it. Pray hard but also drink the medicine.'[159] When the FBOs emphasise these spiritual messages, they deepen trust as identification with clients, many of whom seem to respect their emphasis on compassionate care and God's power.[160] Their spiritual messages also deepen trust as identification with faith-based donors.

Being a knowledge broker necessitates negotiating and mediating between communities. At times, donors and locals may distrust brokers, particularly if these intermediaries seem to prioritise their own needs.[161] In our cases, sometimes the FBOs had divided loyalties, requiring deft manoeuvring to please all.[162] For example, early in its days as a Global Fund recipient, CHAZ felt pressure from its church members to provide them with grants. Yet, it had to be financially accountable, and some of its church affiliates 'just did not have the capacity to write a report or keep a spending ledger'.[163] CHAZ could not give grants to low-capacity partners, but, as one church official who worked closely with churches on AIDS programmes said, some of these local partners questioned why, since they were compassionately meeting a community need.[164] These grassroots organisations' lack of capacity for financial accounting (a form of epistemic power) undermined CHAZ's ability to exercise discretion. Yet, as indicated above, CHAZ over time translated knowledge to local partners through providing them with training on financial management, indicating how brokers continuously jockey for opportunities as they build trust as identification.[165]

A focus on FBOs exposes how trust as belonging is complicated where actors are embedded in bidirectional relations of trust and identification: in this case with both donors and local communities. This bidirectional identification can be leveraged by the FBOs and other local actors to underpin their epistemic, institutional, and network power in a positive power-trust cycle.

Trust as identification and network power

Trust as identification is linked to network power, or the ways that personal, informal connections affect government, donor, and FBO dynamics. Many donor, FBO and government personnel have attended the same schools and worked for other organisations in the health

[156]David Lewis and David Mosse, *Development Brokers and Translators* (West Hartford, CT: Kumarian, 2006).

[157]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[158]Authors' interviews with: CHAZ official, Lusaka, 16 August 2007, 13 April 2009; World Vision official, Lusaka, 15 August 2007. See also Patterson, *African Church and the AIDS Crisis*.

[159]Authors' interview with CHAZ physician, Lusaka, 8 April 2009.

[160]Authors' informal discussions with CHAZ-facility clients, Lusaka, February 2011.

[161]Lewis and Mosse, *Development Brokers and Translators*.

[162]Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[163]Authors' interview with CHAZ official, Lusaka, 13 April 2009.

[164]Authors' interview with Reformed Church official, Lusaka, 31 March 2011.

[165]Hanneke Pot, 'Public servants as development brokers', *Forum for Development Studies*, 46:1 (2019), pp. 23–44.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

sector.[166] For example, prior to 2014 the Director of CHAM worked for the MoH-M and the National AIDS Council, which gave him strong informal ties to government despite the aforementioned breakdown in formal relations.[167] In addition, some donors are nationals or married to local people and part of their networks.[168] Building trust as identification through networks may be more difficult between international donors and locals; because some donor personnel shift from post to post across countries, they cannot easily forge deep relationships with local actors.[169] However, these challenges seemed less apparent with CHAZ and CHAM and their international FBO partners, and there was a striking sense of 'in group' among these actors that respondents conveyed and we observed. FBO officials referred to mutual friends that work at other FBOs throughout the world; they mentioned the faith-based health conferences they attend and their membership in groups like Christian Connections in International Health. Some discussed their education (or their children's education) at Christian universities abroad (for example, Wheaton College-Illinois). Even for individuals with no prior direct experiences with each other, they seemed willing to give each other the benefit of the doubt because of their connections to this faith community.[170]

These informal relations can enable manoeuvering within formal relations and can undergird institutional power in a virtuous cycle. However, they also may create an in-group identity that leads some to distrust those outside of the group, and vice versa. Although space prevents analysis of the issue, this lack of trust as identification has been apparent in HIV prevention programs, in which faith-based actors (both donors and locals) have felt under attack for their emphasis of abstinence and monogamy approaches,[171] while secular (and some religious) groups have felt similarly for their attention to condom distribution.[172] The limited identification between these in-groups can inhibit trust.

Transformation of the power-trust cycle

For CHAZ, economic, institutional, epistemic, and normative power deepened trust as discretion, giving CHAZ the competence to achieve an 'unbroken record of accomplishment', empowering it to meet its commitments and enabling further discretion and influence.[173] For example, CHAZ successfully lobbied the government for a fee waiver for foreign medical volunteers in Zambia if they affiliate with CHAZ.[174] This action benefited hundreds of Christians from high-income countries who travel annually with FBOs to Zambia on medical missions. The policy change increased the organisation's epistemic power (it could bring more experts); its economic power (it could get more faith-based donor support); and its normative power (it could provide more health services). It also reinforced trust as identification between CHAZ and FBO donors such as World Vision that sponsor medical missions. By successfully integrating the dual faces of

[166] Authors' interviews with: programme managers – major international donor, Lilongwe, 6 June, 4, 9, 10 July 2014; health advisor – major international donor, Lilongwe, 7 July, 2014; CHAM official, Lilongwe, 3 July 2014; civil servant – MoH, Lilongwe, 3, 27 June 2014.

[167] Makoka, 'Strengthening PPPs and Interfaith Partnerships for UHC'.

[168] Authors' interviews with: programme managers – major international donor, Lilongwe, 6 June, 4, 9, 10 July 2014; health advisor – major international donor, Lilongwe, 7 July 2014. Anderson, 'Shadow diplomacy'.

[169] Emma Mawdsley, Janet Townsend, and Gina Porter, 'Trust, accountability and face-to-face interaction in North-South NGO relations', *Development in Practice*, 15:1 (2005), pp. 77–82.

[170] Authors' interviews with: international FBOs, Washington DC, 18 March, 11 April 2005; Zambian FBOs, Lusaka, 14, 17 August 2007; Ecumenical church leader, Grand Rapids, Michigan, 24 June 2010; (via telephone) Zambian FBO official, Ndola, 24 October 2008; (via telephone) ecumenical church leader, Lusaka, 10 November 2008; authors' informal discussions with FBO representatives, Lusaka, Washington, DC, Wheaton, Illinois, Grand Rapids, Michigan, 18 March 2005; 9–15 August 2007; 9 November 2008; 13 March 2011; 16 June 2014.

[171] Authors' interview with CHAZ board member, Lusaka, 13 June 2014.

[172] Helen Epstein, *The Invisible Cure* (New York, NY: Picador, 2008); Lydia Boyd, *Preaching Prevention* (Athens, OH: Ohio University Press, 2015).

[173] CHAZ, '2018 Annual Report', p. 9.

[174] Ibid.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

trust as belonging, CHAZ can shape Zambia's discourse on health as a partner with donors. One official, reflecting a broad sentiment within CHAZ, explained that some donors 'have taken our goals, looked at the strategic plan for the nation and our own plan and based priorities on those'.[175] By shaping the debate and defining the possibilities for health in Zambia, CHAZ exhibits the power to affect what others think and do. CHAZ problematises the notion that power and dependency only operate in one direction, from the donor to the local actor.

In contrast, CHAM illustrates that power and trust may intertwine in a vicious cycle. At the time of fieldwork, donors showed limited trust in CHAM, and the organisation acknowledged that donors viewed it to have a damaged reputation (weak normative power).[176] Donors provided relatively few resources directly to CHAM, as shown in Global Fund disbursements. Of Malawi's 13 grants (a total of US $711 million), none went to CHAM as a principal recipient.[177] Low levels of trust undermined CHAM's economic power by limiting access to resources. The resulting low capacity and the perception of limited competence for meeting obligations eroded epistemic power, and CHAM's reliance on DfID to help with financial management partly illustrates this gap. Normative and institutional powers also could not support trust as discretion because CHAM lacked a positive reputation with state officials and could not fully meet the community's demand for care. Unmet obligations undermined any accumulation of the powers that undergird trust as discretion.

Despite these challenges, CHAM shows how trust as identification may create new opportunities to gain various forms of power. Through highlighting shared beliefs and commitments, as well as personal connections, trust as identification enabled CHAM to begin to repair some donor relations after 2014. CHAM's faith-based orientation helped it to point to shared values and forge ties with Norwegian Church Aid and Danish Church Aid, while its embrace of neoliberal practices facilitated ties to USAID in a positive trust cycle. It also secured new project funding from the European Commission and a second award from the US Centers for Disease Control and Prevention for 2015–19. One CHAM secretariat official highlighted that some donors were prepared to 'give CHAM the benefit of the doubt so CHAM can rebuild its reputation by giving small amounts of money'.[178] That is, they were willing to take a first trusting step based on intangible elements such as common values and emerging friendships. In the process, they illustrated an empathy for the other that undergirds trust as identification.[179] This was partly possible because DfID invested in CHAM's capacity building through trainings, and its consultants who worked closely with CHAM staff over several years developed a shared interest in helping the organisation to succeed. Trust as identification helped to begin rebuilding trust as discretion.

CHAM's improved situation illustrates that the power-trust cycle in donor-local relations need not be static. It can be transformed when donors exercise trust as discretion and when they strive to align their objectives with local interests.[180] Trust as identification can make it possible for donors and locals to adopt strategies needed to build long-term equitable professional relationships.

Conclusion

The interaction between trust and power has been neglected in both the IR and global health literatures and yet our research has shown that this interaction is fundamental for global health systems, impacting the possibilities for cooperation between multiple health actors, with

[175] Authors' interview with CHAZ official, Lusaka, 16 August 2007.

[176] Authors' interview with CHAM official, Lilongwe, 3 July 2014; CHAM, 'Strategic Plan 2015–2019'.

[177] The only civil society organisations to receive grants were FBO World Vision International and NGO ActionAid International Global Fund, 'Partner Investments', dataset (2019), available at: {https://data.theglobalfund.org/partners/MWI}.

[178] Authors' interview with CHAM official, Lilongwe, 3 July 2014.

[179] Naomi Head, 'Costly encounters of the empathic kind', *International Theory*, 8:1 (2016), pp. 171–99; Wheeler, 'To put oneself into the other fellow's place'.

[180] See Pfeiffer, 'International NGOs and primary health care'.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

implications for health outcomes. While previous work has often placed trust and power as functional equivalents, treating them as different means to elicit cooperation, we examine how trust and power can interact in asymmetric power relations. In doing so, we recognise that dependency is not simply the outcome of trust but can be a context in which trust is both possible and necessary. Although donors have compulsory power in their relations with local actors through control over funding – placing these relationships outside of the purview of trust by standard IR accounts – trust is still important in circumstances of dependency. We argue this literature must recognise the role of 'trust as belonging' to account for how common identification (shared identities) complements trust as an exercise of discretion (over resources and decisions) in complex relations of dependency.

We extend the IR literature on trust and the global health literature on power by developing the concept of the 'power-trust cycle' to account for the complexity of how various forms of power compound and ameliorate actors' different, shifting vulnerabilities and undergird the competencies that matter for trust; and how trust, in turn, can augment various forms of power. Leveraging this trust as belonging successfully, we contend, can enable local actors to harness different types of power in an effort to offset and mediate the hegemonic power of neoliberalism. This, in turn, extends trust in a virtuous power-trust cycle. Conversely, actors who lack trust find it more difficult to harness alternative means of managing global imbalances of power, a pattern that then deepens distrust in a vicious power-trust cycle.

The power-trust cycle in donor-local relations is not static or immutable. It can be transformed through conscious donor-local efforts to nurture trust as belonging: when actors make requests for trust; when donors take a leap of faith and give local actors discretion over resources and projects; and where donors strive to align their objectives with local interests. Common identification can provide important foundations for donors and locals to build long-term equitable professional relationships. Strategies include coordinating donor action around locally determined plans, building long-term professional relationships that transfer skills (instead of one-off training sessions), and adopting longer project cycles that foster opportunities to recognise shared values.[181] Such strategies also can build trust, for they give actors the space, time, and equal footing on which to recognise commonalities and nurture personal relations.

The power-trust cycle, and the recognition that trust includes both discretion and identification, must be taken seriously in debates about local capacity and institution building, issues that permeate all Sustainable Development Goals.[182] In particular, we challenge donors firstly to embrace a multifaceted view of trust that moves beyond a trust-building agenda that focuses narrowly on transparency and accountability.[183] There are multiple risks when donors and locals embark on a new project, and minimising these risks often requires the other element of trust – trust as identification. That is, donors must be willing to act on those intangible, relational elements that move beyond adopting neoliberal communities of practice but often make achieving outcomes possible. Secondly, donors must recognise the complexity of the power-trust cycle so as to acknowledge that a lack of various forms of power – not a lack of desire – may undermine trust. For example, even if an organisation wants to keep transparent financial records, without sufficient economic power to hire well-trained accountants, it cannot do so. Recognising the complexity of power and trust would open possibilities for greater engagement with the very low-capacity organisations that local communities rely on and trust. Finally, more nuanced views of power-trust linkages would encourage donors to adopt strategies to invest in relationships, nurture shared values, and foster common objectives – all actions needed to foster the trust essential for achieving development objectives and more immediately, improving health outcomes in the COVID-19 pandemic and beyond.

[181]Pfeiffer, 'International NGOs and primary health care', p. 736.

[182]Andrews, Pritchett, and Woolcock, *Building State Capability*, p. 288.

[183]Vincent Keating and Erla Thrandardottir, 'NGOs, trust, and the accountability agenda', *The British Journal of Politics and International Relations*, 19:1 (2017), pp. 134–51.

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press

Acknowledgements. We thank Alexander Beresford, Anna Mdee, and the anonymous reviewers for their feedback and direction on this article. We are also grateful to Claire Brolan, Joseph Harris, and the audience at the ISA Annual Conference in 2019 for their comments and suggestions on an earlier draft of the article.

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Cite this article: Anderson, E.-L., Considine, L., Patterson, A. S. 2021. The power-trust cycle in global health: Trust as belonging in relations of dependency. *Review of International Studies* **47**, 422–442. https://doi.org/10.1017/S0260210521000346

https://doi.org/10.1017/S0260210521000346 Published online by Cambridge University Press