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Rethinking "Structural Violence"

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Abstract The concept of structural violence first developed in the 1960s as a way to explain disparities in health and development between wealthy countries and impoverished postcolonial states. This idea emerged out of Dependency Theory and defined poverty and disease in the developing world as the product of exploitation by colonial or neocolonial powers. Contemporary researchers continue to invoke structural violence to explain international health trends, but a review of recent literature reveals that the concept is increasingly outdated and poorly theorized. It is especially problematic when used to describe contemporary epidemics of infectious disease. In this paper I offer a brief overview of the concept of structural violence and critique the way it has been used to explain the political economy of two recent outbreaks: Ebola in West Africa and cholera in Haiti. Ultimately the paper concludes that these scholars claim to be explaining epidemics but instead use their research as a form of moralistic storytelling that leaves the structural dimensions of health unexplored.

Keywords Structural violence · Health disparities · Imperialism · Ebola · Cholera · Haiti · Liberia · International health · Political economy

Political Economy of Health: Twentieth Century Edition

In the nineteenth century, Marx and Engels argued that capitalism increased poverty, disease and early death among the working class. This connection would have been obvious to anyone traveling through rapidly urbanizing factory towns in England during the early years of the Industrial revolution, prior to the development of the germ theory of disease. At that time mortality rates were extraordinarily high and sanitation was non existent. Infectious diseases like tuberculosis, typhoid and measles killed a high percentage of working class children, and periodic outbreaks of cholera decimated entire communities.[1]

Advances in public health and medical science eventually brought many of these diseases under control in the United States and Europe, leading Soviet theorists like Lenin to transfer their attention to health conditions in underdeveloped or postcolonial countries. In his writings on imperialism, Lenin argued that poor countries could not modernize (including modernization of health) as long as they remained exploited by the world capitalist system.[2] These ideas were more formally articulated by M.N. Roy, one of India's early Communist Party leaders, who was selected by Lenin to speak at the Second Congress of the Communist International in 1920. At that time Roy wrote, "One of the main sources from which European capitalism draws its basic strength is in the colonial possessions and dependencies".[3] In this statement he is using Lenin's ideas to lay the foundation of what would eventually become known as Dependency Theory. Dependency theory became popular in the 1960s and 1970s as a critique of modernization's ideology of gradual, universal progress.

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[1] Ron Barrett and George Armelagos *An Unnatural History of Emerging Infections*. Oxford: Oxford University Press, 2013.
[2] Gy. Ranky and F. Horner "A Few Comments on Lenin's Work 'Imperialism.' " *Acta Historica Academiae Scientarum Hungaricae*, 1977 22(1–2):131–138.
[3] James Roberts "Lenin's Theory of Imperialism in Soviet Usage", 1977 *Soviet Studies*, 29(3):358.

The unifying thread that connects Soviet critiques of imperialism, Dependency theory and contemporary research on international health is the concept of "structural violence." This phrase was first developed by Johan Galtung, a European peace studies researcher who authored several influential articles in the 1960s and 1970s.[4] In its original formulation, structural violence specifically referred to the violence of imperialism, or the collective suffering imposed by wealthy "core" countries on poor "peripheral" countries.

Galtung's writings about structural violence were an attempt to formalize the ideas of Dependency theory into a more rigorous typology of imperial violence. In his 1969 article, for instance, he expanded his definition of structural/imperial violence to address the issue of preventable disease. "Thus," he stated, "if a person died from tuberculosis in the eighteenth century it would be hard to conceive of this as violence since it might have been quite unavoidable, but if he dies from it today, despite all the medical resources in the world, then violence is present according to our definition.[5]" In this passage Galtung is arguing that inequalities in access to curative medical technology are a form of imperial or structural violence.

Research exploring the intersection of imperialism and health gained additional popularity in the 1990s through the high profile work of physician-anthropologist Paul Farmer, who combined ground-breaking research in Haiti with direct delivery of clinical services to some of the world's most impoverished communities.[6] Farmer's analyses of emerging infectious disease focused primarily on convergent epidemics of tuberculosis and HIV. In recent years he and his colleagues have also addressed the devastating effects of cholera following the 2010 earthquake.[7]

Paul Farmer's analysis of health patterns in Haiti has followed Galtung's Leninist model. In his books and articles, Farmer used historical material to illustrate how Haiti's experience of colonization (including neocolonization by the United States in the early twentieth century) produced extreme levels of poverty and disproportionately high rates of infectious diseases like HIV and tuberculosis. In 2001 he published a paper in *Current Anthropology* that further developed Galtung's framework and proposed that researchers should situate health conditions in postcolonial regions within "large scale social and economic structures".[8] Throughout his work Farmer has consistently focused on racism and imperialism as the structures most relevant to making sense of Haiti's chronic poverty and high rates of infectious disease.

Farmer's article in *Current Anthropology* also includes commentary from six other anthropologists who offer reflections on the idea of structural violence, including Loic Wacquant, Phillipe Bourgois and Nancy Scheper-Hughes. These authors express deep admiration for Farmer's humanitarian work in Haiti, but several of them also voice concerns about the limitations of structural violence as an explanatory framework for understanding health patterns. Unfortunately, few of these criticisms have been remembered today. A review of recent literature in the social sciences and humanities reveals structural violence is now used to explain all manner of health conditions and human problems that bear little connection to Galtung's or Farmer's original formulations.[9] Structural violence has also been invoked to explain Ebola in West Africa[10] and cholera in Haiti.[11]

Ebola as Structural Violence?

Ebola is a new, incurable virus that has only recently crossed over from its animal reservoir species to infect humans. This means the human immune system has no history of exposure to this pathogen, and the mortality rate is correspondingly high. There are no effective treatments other than rehydration and supportive care. Even with good supportive care almost half of the patients who contract Ebola will die.

Two groups of researchers have written papers describing the 2014 Ebola epidemic as an example of structural violence. Adia Benton and Kim Yi Dionne, for instance, describe Ebola

[4] Johan Galtung "Violence, Peace and Peace Research," 1969 *Journal of Peace Research* 6(3):167–191; "A Structural Theory of Imperialism" 1971 *Journal of Peace Research* 8(2):81–117.

[5] 1969:168

[6] Paul Farmer *AIDS and Accusation: Haiti and the Geography of Blame,* 1993 Berkley: University of California Press; Paul Farmer *The Uses of Haiti* 1994 Monroe, Maine: Common Courage Press.

[7] Alsan, Marcella, Westerhaus, Michael, Herce, Michael, Nakashima, Koji, and Farmer, Paul "Poverty, Global Health and Infectious Disease: Lessons from Haiti and Rwanda." 2011 *Infectious Disease Clinics of North America*, 25(2):611–622.

[8] Paul Farmer "An Anthropology of Structural Violence." 2001 *Current Anthropology*, 45(3):305–325.

[9] Dossa Parin "Structural Violence in Afghanistan: Gendered Memory, Narratives and Food." 2013 *Medical Anthropology*, 32:433–447; Qureshi, Ayaz "Structural Violence and the State: HIV and Labor Migration from Pakistan to the Persian Gulf," 2013 *Social Science and Medicine* 20(3):209–220; Schuller, Mark "'Pa Manyen Fanm Nan Konsa'": Intersectionality, Structural Violence and Vulnerability Before and After Haiti's Earthquake, 2015 *Feminist Studies*, 41(1):184–210; Wendy Vogt "Crossing Mexico: Structural Violence and the Commodification of Undocumented Central American Migrants," 2013 *American Ethnologist*, 40(40:764–790.

[10] Adia Benton and Kim Yi Dionne "International Political Economy and the 2014 West African Ebola Outbreak," 2105 *African Studies Review*, 58(1):223–236; Annie Wilkinson and Melissa Leach "Briefing: Ebola—Myths, Realities and Structural Violence," 2014 *African Affairs*, 114(454):136–148.

[11] Marcella Alsan, Michael Westerhaus, Michael Hence, Koji Nakashima and Paul Farmer "Poverty, Global Health and Infectious Disease: Lessons from Haiti and Rwanda" 2011 *Infectious Disease Clinics of North America*, 25(2):611–622.

as configured by sequential intersections of racism and imperialism in West Africa. They identify the Transatlantic slave trade, the abuses of the colonial era, the structural adjustment programs of the 1980s and finally the destructive civil wars of the 1990s as forms of imperialism that "shaped the conditions that spurred and intensified the spread of Ebola in the region".[12]

In their 2014 paper, Annie Wilkinson and Melissa Leach also interpret Ebola as structural violence, though in a less coherent fashion. "The Ebola crisis," they wrote, "has emerged from the meeting of long-term economic, social, technical, discursive and political exclusions and injustices, now shown to be dramatically unsustainable".[13] These authors go on to formally define structural violence in the context of Ebola as "overlapping institutions and practices that have produced interlaced inequalities, unsustainabilities and insecurities…in a set of localities long interconnected with a global world through colonial and post-colonial political and economic relations".[14]

These arguments are problematic. In Galtung's original 1971 article, he specifically indicated that an incurable disease (such as tuberculosis in the 1800s) should *not* be considered an example of structural violence. The concept was intended to refer to differential mortality from avoidable deaths. How many Ebola deaths were avoidable? This is a complex calculation given that there is no effective drug treatment for the disease and the only way to prevent the spread of the virus in 2014 was through isolation and quarantine of individuals known to have been exposed. Isolation and quarantine are notoriously difficult to organize and enforce, especially for a lethal disease. Patients inevitably resist being separated from their families in a time of crisis and actively resist quarantine measures. This poses a number of logistical and ethical challenges for medical teams, especially in the early phases of an epidemic when popular awareness of risk is low. But researchers writing about Ebola seem unaware of these dynamics and imply that difficulties containing the virus were configured by centuries of colonial oppression instead of the specific properties of the disease itself, or the logistical challenges of enforcing quarantine in remote rural areas.

Researchers invoking structural violence to explain Ebola also fail to identify why Liberia was one of the three most afflicted countries since it does not share the same history of colonization as its neighbors. Liberia's unique past is easy to overlook, given that it suffers many of the same problems as other countries in the region. But Liberia was originally founded in the early 1800s as a haven for returned North American and Caribbean slaves. It was formally recognized by the United States in 1862.

In the 1920s Firestone became the first major North American company to establish a presence in the country. Benton and Dionne have described Firestone's rubber plantation as equivalent to a colonial entity, but other sources suggest the relationship between Liberia, Firestone and the United States was more complex.[15] Firestone, for instance, provided rudimentary medical services to plantation workers, making them part of a very small number of people in the country with access to professional health care during that time. There were only two practicing physicians in the capital city of Monrovia in the 1920s, and virtually none in rural areas. The country suffered high rates of "elephantiasis, leprosy, yaws, malaria, hookworm, schistosomiasis, dysentery, smallpox, and nutritional deficiencies".[16]

The U.S. government made some limited efforts to improve health conditions in Liberia during the early twentieth century. In 1929 a sanitary engineer was sent by the U.S. Public Health Service to help control an outbreak of yellow fever.[17] Shortly after his arrival, he trained a team of Liberian workers to undertake a health census to record living conditions, mortality rates and demographic data for every residence in Monrovia. A public health nurse joined the team and assisted in training the corps to identify different mosquito species and eliminate breeding areas specific to the *stegomyia* mosquitos known to carry yellow fever. Together they prepared an outreach campaign to educate the general public about basic household prevention measures such as covering water barrels and eliminating trash around living spaces.

These public health efforts were initially successful, and there was a significant reduction in yellow fever mortality soon after the completion of the mosquito reduction program. But the Liberian government did not abide by the terms of its agreement with the United States to support ongoing sanitation work. In correspondence to his superiors in Washington the U.S public health officer stationed in Monrovia offered the following assessment,

> My own personal opinion in this matter is that the local government has absolutely no interest in any sort of sanitary program for the country and will do absolutely nothing to inaugurate or to assist in carrying out…any program relating to any form of sanitary improvement for the city of Monrovia or for the country at large….Under present conditions and with no funds

[12] 2015:225
[13] 2014:137
[14] 2014:146

[15] G.E. Boley *Liberia: The Rise and Fall of the First Republic,* 1983 New York: St. Martin's Press; Stephen Ellis *The Mask of Anarchy: The Destruction of Liberia and the Religious Dimension of an African Civil War,* 1999 Washington Square, New York: New York University Press.
[16] Graham Greene *Journey Without Maps*, 1936 New York: Doubleday, p. 7.
[17] This information comes from Record Group 90, records of the United States Public Health Service located at the National Archives Facilities in College Park, Maryland.

> available the time of any person sent here to do sanitary work is absolutely wasted.[18]

This brief historical vignette raises a number of questions about the relationship between U.S. imperial power and patterns of infectious disease mortality in Liberia during the early twentieth century. Do the actions of the United States government in Liberia fit Galton's definition of imperial violence? Who was ultimately responsible for the resurgence of yellow fever following the cancellation of the urban mosquito control program and how did political and/or economic considerations influence these decisions? These are historical questions, answerable through archival research, but researchers who rely on structural violence to explain health conditions in West Africa have not pursued these kinds of inquiries.

There is one area in which Liberia's twentieth century history does converge powerfully with that of other Ebola afflicted countries. Liberia, Sierra Leone and Guinea all experienced similar patterns of instability and "warlord politics" in the 1990s and early 2000s.[19] These conflicts appear to have been fueled by competition over natural resources like diamond mines and timber reserves. Historical research exploring the political economy and violence of illicit resource extraction in the 1990s could potentially explain a good deal about how the region became so overwhelmed by the appearance of a lethal infectious disease in 2014. But neither group of Ebola researchers cited above has explored the West African civil wars in detail as these internal conflicts are not easily categorized as acts of imperialism.

Cholera as Structural Violence?

Unlike Ebola, cholera is a preventable and treatable bacterial disease. It is waterborne and results in death from severe dehydration from diarrhea very quickly. Patients can die within hours if they are not given electrolyte and fluid replacement. Cholera decimated many urban populations in India, Europe and the United States in the 1800s. The noxious smell of densely populated slum areas was so overpowering that nineteenth century physicians came to believe that poisonous vapors (called miasmas) were responsible for the high mortality observed in these neighborhoods. Eventually the germ theory of disease became too convincing to ignore and massive engineering projects were undertaken to connect urban areas to sewer systems that would prevent human and animal waste from contaminating supplies of drinking water. By the middle of the twentieth century, cholera outbreaks were increasingly rare. A moderately effective oral vaccine was developed in the 1990s.

Haiti's experiences with cholera since 2010 do fit Galtung's original definition of an epidemic configured by structural violence. Cholera can be prevented with infrastructure improvements that prevent human waste from contaminating drinking water supplies. If conditions are not in place to undertake these kinds of large engineering projects, cholera can still be prevented by vaccine. Since the vaccine is only about 60% effective, patients who get cholera despite being vaccinated can be treated with inexpensive rehydration procedures and antibiotics that will reduce the mortality rate down to around 1%.[20] Any region experiencing high mortality from cholera today, when all of these technologies are available is clearly suffering from political and economic failures that indicate serious human rights problems. But why? How did Haiti end up in such dire conditions?

In one recent article, Paul Farmer and several colleagues link Haiti's inability to contain cholera to the country's history of colonization and economic exploitation by imperial powers, including the United States. These authors identify legacies of slavery, crushing international debt burdens and U.S. imperial control during the nineteenth and twentieth centuries as the main structural reasons why Haiti has never been able to develop its infrastructure sufficiently to provide clean drinking water for the population. This narrative reflects Galtung's original model of structural violence in that it explicitly links mortality from preventable disease to predatory economic policies of various international actors. But it is not consistent with historical research into the health effects of the U.S. military occupation of Haiti in the early twentieth century.

The occupation of Haiti was clearly racist, oppressive and unpopular.[21] But it paradoxically included extensive public health work and infrastructure development by the U.S. Public Health Service and the U.S. military. There was a belief at the time that Haiti's chronically unstable government was a key factor in the country's poverty and underdevelopment. The decision to send U.S. troops to occupy the Island in 1915 was regarded as an opportunity to stabilize the country's governance structures, improve its finances, reduce violence and provide assistance so that Haiti's human resources and commercial potential could be properly developed.

Improving health and sanitation was a high priority for the military since American soldiers stationed in Haiti were at risk

[18] Report from H.F. Smith, U.S. Public Health Officer in Liberia to American Charge D'Affairs, American Legation Monrovia, Liberia February 5 1931

[19] Tom Burgis *The Looting Machine: Warlords, Oligarchs, Corporations, Smugglers and the Theft of Africa's Wealth*, 2015 New York: Perseus Books; Willian Reno *Warlord Politics and African States*, 1999 New York: Lynne Reiner.

[20] http://www.who.int/mediacentre/factsheets/fs107/en/

[21] Charles Chapman "The Development of the Intervention in Haiti," 1927 *The Hispanic American Historical Review*, 7(3);299–319; A.C. Millspaugh "Our Haitian Problem" 1929 *Foreign Affairs*, 7(4):556–570; Clarence Streit "Intervention Irks Proud Haitian Folk" 1928 *New York Times*. February 19; Ulysses Weatherly "Haiti: An Experiment in Pragmatism," 1926 *American Journal of Sociology*, 32(3):353–366.

from deadly diseases circulating in the country. To address these problems, the U.S. Navy conducted a successful pilot study of malaria prevention for soldiers in rural communities, and a number of public health officers were deployed throughout the country to oversee health surveys, mosquito control and hospital construction.[22] A nursing school was founded so that Haitians could be trained to carry on health work after the U.S. vacated the Island, and the Rockefeller Foundation helped fund a free medical college to train Haitian doctors.[23] Public health engineering crews drained malarial swamps, built roads, improved urban water supplies and distributed mosquito nets.

After the end of the occupation, Haiti and the United States pledged to continue joint work "for the sanitation and public improvement of the Republic" in a formal treaty arrangement signed in 1931.[24] But over time these programs lapsed as new instability erupted in the 1940s. Order was eventually restored during the repressive Duvalier dictatorship, which continued into the 1980s. Despite training as a physician, the elder Duvalier demonstrated little interest in continuing the public health work begun in the 1920s.

This abbreviated review of Haiti's twentieth century health history does not appear to support Galtung's model of imperial violence as the singular cause of Haiti's twenty-first century problems with cholera. According to several reports, the United States oversight of Haiti's national treasury resulted in a $200 million surplus at the end of the occupation.[25] The Duvalier family, on the other hand, was estimated to have stolen hundreds of millions of dollars in public revenues during their decades in office.[26] Which of these exploitive structures bear the greatest responsibility for Haiti's poverty and poor health indicators—U.S. imperialism or Duvalier's kleptocracy? This is also an empirical question that would benefit from further archival and ethnographic research, but scholars studying political economy of health in Haiti have not undertaken this kind of research.

Galtung's definition of structural violence also has limitations for making sense of Haiti's contemporary struggles with cholera because it does not explain the health disparities that occur *between* neighboring post-colonial countries. Haiti's history of exploitation parallels that of its closest neighbor, the Dominican Republic. Both countries began as European colonies of France and Spain, respectively. Both were subject to unwanted military occupation by the United States in the early years of the twentieth century and both suffered the predations of rapacious dictators (Rafael Trujillo and Francois Duvalier) during the Cold War. Both countries have had high international debt burdens and occasional periods of low intensity conflict in border regions. Both countries have also had cholera introduced in recent years, but the rate of spread and the overall mortality pattern has been very different across national boundaries.

According to the Public Health Agency of Canada, since 2010 Haiti has had over 750,000 cases of cholera with 9000 related deaths while the Dominican Republic has had over 33,000 suspected cases of cholera and approximately 500 related deaths[27] Both countries have roughly the same population, but great disparities in wealth (as measured by per capita income and GDP), literacy, life expectancy and indices of political corruption. But these variables are not investigated by researchers interested in political economy of health.

Cases of cholera have also been exported from Haiti to Mexico, Venezuela, the United States and Cuba. But the disease has been brought under control in these countries relatively quickly and no major mortality resulted. If cholera in Haiti is explained as a manifestation of structural violence, why is Haiti the only postcolonial state in the region still suffering high mortality while other impoverished postcolonial countries are not? The devastation of the 2010 earthquake is obviously a factor, but how do Haiti's struggles with cholera compare with other countries that have experienced catastrophic natural disasters? Nepal, Sumatra and Chile have all suffered massive earthquakes over the past decade, but there has not been have not any comparative research exploring how these countries have recovered from colonial exploitation *and* natural disasters.

Political Economy of Health: from Imperialism to Empiricism

Rigorous comparative ethnographic and archival research that explores the intersection of politics, economics (including illicit economies of political corruption) and the natural environment should be the starting point for scholars interested in social and economic determinants of epidemic infectious disease. But the field does not take this approach. Instead of developing empirical questions that could help refine theory and improve definitional clarity of core concepts, contemporary researchers collect narratives that validate Lenin's assumptions about imperialism. This approach makes Galtung's model unfalsifiable and

[22] United States Public Health Service "Anti-Malaria Campaign Conducted in Haiti by Naval Medical Officers" 1923 *Public Health Reports*, 38(46):2721–2723.

[23] *American Journal of Nursing* "Thirty Years of Nursing in Haiti", 1949. 49(10):643–644; *New York Times*, February 19, 1928

[24] *American Journal of International Law*, "Agreement between the United States and Haiti" 1933 27(4):159–162.

[25] Clarence Streit "Intervention Irks Proud Haitian Folk," *New York Times* February 19.

[26] http://www.cnn.com/2011/WORLD/americas/01/19/haiti.duvalier.assets/. Accessed 9 July 2016.

[27] http://www.phac-aspc.gc.ca/tmp-pmv/notices-avis/notices-avis-eng.php?id=111.

substitutes a moral argument against imperialism in place of objective historical or ethnographic research exploring how macro level structures configure patterns of disease.

Epidemics move through time and space in predictable ways, configured by variations in human immunity, population density and pathogen virulence. Variables in the social environment like malnutrition, housing, and sanitation also play a role in configuring human vulnerability. But over-reliance on poorly defined concepts like structural violence erases these axes of variation and explains all epidemics in post-colonial countries with one predetermined, unfalsifiable narrative.

Research linking imperialism to poor health conditions in post-colonial countries had more credibility in the 1970s when Galtung's writing first became popular. But the world has changed since that time and many of his original assumptions are no longer accepted due to their inability to explain or predict events that have occurred in the new millennium. In Galtung's era, international health and development specialists assumed modernization of mortality patterns was a one-way process that could not be reversed. So a country that underwent modernization of its mortality profile through control of infectious disease was not expected to regress to an earlier developmental stage.

But the 1990s and the early 2000s there were many examples of reverse mortality transitions involving resurgence of preventable infectious diseases in industrialized countries. These were common in states with high levels of political corruption, civil wars and conflict between Violent Non-State Actors[28] like organized crime groups. One scholar, for instance, described Russia in the 1990s as undergoing a process of "thirdworldization" whereby the former industrial superpower became afflicted by problems typical of impoverished underdeveloped countries. These included "mass poverty, hunger, regional conflicts and ethnic wars, deindustralization and huge foreign debt, corruption of the elites and governing juntas, bloody coups d'etat, outbreaks of long forgotten diseases, refugee problems, environmental degradation and societal and state collapse".[29]

The political economy of state failure, epidemiological underdevelopment and "thirdworldization" are still not fully theorized, but some common patterns have been identified.[30] The Fund For Peace (a non profit security studies group), for instance, has created an index of fragility to rank states according to their potential for failure or collapse. In 2015 Haiti was categorized as "high alert" status meaning it was in the second riskiest tier, together with other chronically unstable regions with high rates of water borne diseases like Afghanistan, Iraq and Zimbabwe.[31]

Do the same political and economic processes that create state failure and fragility also produce widespread poverty and epidemics of preventable diseases like cholera? There is some anecdotal evidence to support this argument. One anthropologist, for instance, has described witnessing Haitian officials loot foreign aid intended to alleviate poverty, improve health and promote socioeconomic development in the country.[32] According to Schwartz, this has led to a perverse scenario whereby increasing foreign aid has actually resulted in negative health and mortality trends for one region. "When the money, materials and food arrived…the Haitian employees, politicians, administrators, pastors, priests and school directors embezzled it and when they had accrued enough money, most of them migrated to Miami…This left the poorer peasants behind to deal with the disaster…".

Have predatory officials also looted aid money and supplies intended to prevent cholera from spreading? Are lifesaving rehydration supplies and equipment being stolen from public clinics so that poor patients have no access to treatment? These are the kinds of questions social scientists should be asking about Haiti's current health crisis—empirical questions that can be answered through a combination of historical and ethnographic research exploring how interlocking structures at international, state and local levels have configured population vulnerability to lethal infectious disease.

But scholars do not seem interested in conducting grounded empirical research exploring how the unique political economy of fragile states facilitates resurgent epidemics of preventable disease. They rely instead on a predetermined Leninist narrative that implicitly defines epidemics in poor countries as manifestations of imperial or structural violence. This narrative is often presented without supporting historical research, so the story of imperialism in a given location is not a literal history of a specific place and time, but moral story of

[28] Robert Bunker (ed.) *Non-State Threats and Future Wars,* 2003 Portland, Oregon: Frank Cass.; Robert Bunker "Public Looting for Private Gain: Predatory Capitalism, MNCs and Global Elites, and Plutocratic Insurgency," In, *Global Criminal and Sovereign Free Economies and the Demise of the Western Democracies: Dark Renaissance*. Robert Bunker and Pamela Liguori Bunker, eds. 2015 London: Routledge, pp. 134–162.

[29] Leonid Fituni "The Collapse of the Socialist State: Angola and the Soviet Union." In, *Collapsed States: The Disintegration and Restoration of Legitimate Authority*, 1995 William Zartman (ed.) Boulder: Lynne Reinner, pp. 143–156.

[30] Natasha Ezrow and Erica Frantz *Failed States and Institutional Decay: Understanding Instability and Poverty in the Developing World,* 2013 London: Bloomsbury; Katherine Hirschfeld *Gangster-States: Organized Crime, Kleptocracy and Political Collapse*, 2015 Basingstroke, UK: Palgrave MacMillan; Robert Rotberg "Failed States, Collapsed States, Weak States: Causes and Indicators," In, *State Failure and State Weakness in a Time of Terror,* Robert Rotberg, ed. 2003 Cambridge, Massachusetts: World Peace Foundation, pp. 1–28; William Zartman Introduction. In, *Collapsed States: The Disintegration and Restoration of Legitimate Authority,* William Zartman, ed. 1995 Boulder: Lynne Reinner, pp. 1–14.

[31] http://fsi.fundforpeace.org/rankings-2015.

[32] Timothy Schwartz *Travesty in Haiti*, 2011 Smashwords Edition.

unjust suffering at the hands of temporally and geographically remote, vaguely defined malevolent structures. In this sense, imperialism and structural violence resemble twenty-first century miasma—a vaporous, unscientific theory of disease that draws appeal from scholars' collective revulsion against anything that smells like colonialism, but contributes little to understanding patterns of emerging infectious disease in the twenty first century.

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