Shifting power in global health
Decolonising discourses — Series Synthesis

Convened by

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UNU-IIGH
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SHIFTING POWER IN GLOBAL HEALTH
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INTRODUCTION

There have been an increasing number of voices – both individual and institutional – that have called for a reassessment of global health and greater recognition of its colonial heritage. (1) Whilst there is currently no unified definition of what it would mean to decolonise global health, in its broadest sense, it has been described as the 'imperative of problematising coloniality'. (2)

It is within this context that the "Shifting Power in Global Health: Decolonising Discourses" series was co-convened by the United Nations University's International Institute for Global Health, Development Reimagined, and Wilton Park. Held as a set of three dialogues between November 2021 and May 2022, the series took as its point of departure the many discussions, webinars, and publications presenting the ways coloniality manifests within global health, with the aim of shifting from problematising coloniality to catalysing decoloniality. While colonialism refers to the physical occupation of a bounded territory, coloniality, in both its historical and present-day manifestations, is understood as a globally persistent and geographically unbounded extractive process that drives inequities. Consequently, while decolonisation is easily recognised by the physical removal or exit of the colonising force, a similarly straightforward definition for decoloniality is not so easily found.

DIALOGUE REPORTS

1

Decolonising discourses began to articulate the ideas and visions of different groups for what a decolonised global health could look like and identify points of convergence.

2

Voices and lessons from across the South picked up the conversation with a focused discussion on South-South partnerships and their power dynamics; South-North alliances; and the role of global funders in South-South collaborations.

3

The global South and global health finance presented opportunities for the panellists and participants to discuss the mechanisms that global South practitioners, academics, and advocates can implement to harness their agency over global health finance.

1 Pai M. (2021, July 22). Decolonising global health: A moment to reflect on a movement. *Forbes*.

2 Hirsch LA. (2020). In the wake: Interpreting care and global health through Black geographies. *Area, 52*(2), 314-321. DOI: 10.1111/area.12573

The challenge of 'knowing decoloniality when we see it' is in part due to the varied and contextual ways that coloniality manifests. As such, there is no single movement to decolonise global health, rather, a diverse plurality of initiatives that lends richness and context to this vast endeavour. The organisers did not seek to craft from these dialogues a singular and universally accepted definition of decoloniality that reads as a list of exclusion criteria; rather, the priority is to identify commonalities to enable us to recognise decoloniality when we see it as well as consider how to scale and amplify these actions and initiatives.

The series encouraged organisers and participants alike to lean into "constructive discomfort" and interrogate such elements as:

- Language: Do the terms "global South" and "global North" perpetuate a binary and static idea of coloniser/colonised and, in so doing, mask complexities within countries/regions and similarities between countries/regions?
- Representation: Whose voices are missing, and through whose lens? Does representation convey agenda-setting and decision-making power, or is it merely an exercise in tokenism? Are there infinite seats at the table to be filled, or will/should some people relinquish their seats to make space for others?
- Positionality: The vast reach of both colonialism and coloniality have made it such that we are all situated within systems of oppression. How do we reflect on, navigate, and perhaps shift our own positions, recognising that while not everyone should be a leader of change, everyone can be an agent of change?

To generate a safe and diverse space conducive to the rich conversations required for these topics, the organisers co-designed a methodology which included the following components:

- Each dialogue was held twice at different times on the same day to facilitate wide geographic participation.
- Discussions, conducted in a mix of plenary and breakout, were held under the Wilton Park protocol, which employs non-attribution to facilitate frank and honest conversation.
- Per a recommendation from the second dialogue, global North attendees from the first two dialogues were invited to nominate a global South practitioner to "take their seat" for the third and final dialogue.

A total of 65 participants attended either one, two, or all of the dialogues, representing all six WHO regions of the world. Invited 'provocateurs' delivered brief plenary interventions to stimulate discussion. A conscious decision was made to have unique speakers across all three dialogues, increasing the diversity of perspectives.

There was much to learn from the nuanced and lively discussions that took place and what follows is a synthesis of those six conversations. This process was not envisioned as one by which to achieve consensus; as such, this summary does not claim to be a definitive account of what it would mean or take to decolonise global health. Instead, we hope this synthesis will show the richness of the decolonising global health movement, highlight some of the initiatives already taking place, and outline some next steps.

KEY TAKEAWAYS

1. Shifts in power - at the individual, structural, and systemic levels - are urgently needed.

Despite multiple attempts at reconfiguration, the underlying power structures of global health remain vastly unchanged from those of its predecessors, tropical medicine and international health. By and large, the distribution of agenda-setting and decision-making power within global health remains strikingly colonial; (3) even the parameters in which agendas and decisions are crafted are more often than not pre-determined by key players in the global North who continue to wield outsized intellectual authority and material power. There is a clear and urgent need for significant shifts in power that extend beyond tokenistic representations of diversity to consider what more deep-seated structural and systemic shifts would entail – to move beyond reallocating seats at the table and instead reconsider and perhaps redesign the table itself.

While systems and organisations have a clear role in fulfilling this change, individuals must also lean into constructive discomfort and embrace a mindset shift that recognises every person has the potential to be both agents and objects of decoloniality. For some, this exercise in reflexivity might lead to a reconsideration of where they fit in this new agenda, with an understanding that while everyone has a role to play, individual responsibilities and actions will vary. Some will find their role to be one that focuses on individual change, grappling with internalised ways of thinking and working. Others still might find themselves playing a role in changing systems, by supporting or creating facilitating environments for change and advocating for colleagues with less social or political capital. Finally, those with relevant lived experiences will be uniquely positioned to lead the push for change at a structural level.

2. Global health does not exist in a vacuum and must be interrogated within broader contexts.

Far from existing in a vacuum, global health operates within a broader context of historical legacies and their direct bearing upon contemporary political struggles and economic imperatives. (4) The symptoms of injustice and inequity within global health practice and research point to a disease within a larger political and economic architecture rife with power imbalances that perpetuate dependency under the guise of development aid. However well-meaning, all power holders connected to global health must be interrogated in examining how political agendas and economic expansion infiltrate global health programming through the provision of tied funding, the imposition of external policies and priorities, tolerance of conflicts of interest, and the reification of Northern expertise.

3 Lawrence DS, Hirsch LA. (2020). Decolonising global health: Transnational research partnerships under the spotlight. *International Health, 12*(6), 518–23. DOI: 10.1093/inthealth/ihaa073
4 Holst J. (2020). Global Health - Emergence, hegemonic trends and biomedical reductionism. *Globalization and Health, 16*(1), 42. DOI: 10.1186/s12992-020-00573-4

At the same time, to rebalance, reform, and redesign global health architecture, all stakeholders must be engaged in the movement(s) to decolonise global health. Practitioners with local expertise and experience, activists with community connections and strategies, and a plethora of actors who often go unheard in the din of global health chatter must be seen as partners in this endeavour with equal, if not greater, amounts of knowledge to identify key challenges and inform ways forward.

3. Decolonising global health is a social movement, not an academic exercise.

Global health is not merely an academic field of study but a set of practices that significantly impact the day-to-day lives of some eight billion people. As such, the movements to decolonise this system and create a more equitable global health cannot be merely an academic exercise but must be recognised as a social and political endeavour for structural change and shifts in power rooted in collective action. A coalition built on shared principles and a plurality of approaches will only strengthen the movement.

An advocacy-centred approach to decolonising global health creates space for discourse on redistributive, restorative, and reparative justice for those who continue to suffer contemporary failings that trace their origins to colonial actions, such as the destruction of traditional health structures in favour of biomedical systems incompatible with local contexts. Many former colonies are saddled with underfunded health systems modelled after and created by colonial forces. A prime example of persistent coloniality, the constant need for aid to support these systems and meet externally set targets generates continued dependency and perpetuates power imbalances.

4. Funding can both exacerbate and alleviate power imbalances.

Confronting coloniality within funding models is crucial to rebalancing power dynamics *vis a vis* dispelling paternalistic views about the global South requiring constant support from the global North. Traditionally, global health funding has predominantly flowed from the North to the South, often with prerequisites that either further donor political agendas, spread economic ideologies, or impose external priorities. These drivers have been known to contribute to and often create additional burdens through complex monitoring and evaluation requirements. New funding models that eschew bilateral arrangements in favour of multilateralism, operate without strings or stipulations, and respond to locally identified needs would shift power from donors to the doers. Greater South-South cooperation in the form of funding could work to alleviate the traditional power imbalance along geographic lines, but care must be taken to avoid a mere transfer of dominance rather than an interrogation of it.

Beyond reconsidering how funding is allocated, decolonising global health also raises the prospect of reconsidering how funds are generated. As the call for reparations grows louder, so do conversations about how such funds might be used to improve the well-being of formerly colonised populations that continue to be marginalised by health

systems today. In a more contemporary context, insufficiently developed and enforced tax systems also allow for the continued outflow of resources from former colonies that vastly outweigh the inflow of development aid. A more robust global tax system would stem this outpouring and generate revenue for local governments and ownership over systems and structures that are locally funded and not beholden to the strings and agendas of external parties.

5. Change is possible — and already happening.

Change within funding, practice, and research is not only urgently needed but already starting to take shape. It is crucial that we acknowledge such actions and achievements, which can better inform the inclusion criteria for recognising decoloniality when we see it. To that end, some emerging practices and promising initiatives identified throughout the series are shared here for further exploration.

Several existing codes of practice seek to redress power imbalances, especially within research, including the San Code of Research Ethics, (5) the Commission for Research Partnerships with Developing Countries (KFPE) Guide for Transboundary Research Partnerships, (6) and the Research Fairness Initiative. (7) There also exist fora for funders seeking to work more equitably, including the UK Collaborative on Development Research (UKCDR) (8) and ESSENCE. (9)

There is, however, still a need to further close the gap between rhetoric and practice. Noteworthy examples of promising practice include the rise of regional consortia, such as CARTA, (10) which focuses on global knowledge production and research capacity building in Africa, by Africans, for Africa, and organisations such as PIVOT, (11) which relocated their headquarters from the US to Madagascar where their health programmes are implemented, and reconfigured their leadership team which is now two thirds' Malagasy. Looking at the funding landscape, the Alliance for Accelerating Excellence in Science in Africa (AESA) (12) was founded by a consortium of funders seeking to shift the centre of gravity for African science to Africa by distributing funds based on locally designed agendas. (13) Beyond the allocation of resources, Grand Challenges Canada (14) is complementing their grant quotas with advocacy for more donor flexibility, so LMIC-based actors not only receive 80-90% of their funding but are also given greater freedom in using those funds to respond to local needs.

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5   The San Code of Research Ethics.
6   Stöckli B, Wiesmann U, & Lys A. (2018). *A Guide for Transboundary Research Partnerships: 11 Principles* (3rd edition). Bern, Switzerland. Swiss Commission for Research Partnerships with Developing Countries (KFPE).
7   The Research Fairness Initiative.
8   UK Collaborative on Development Research.
9   ESSENCE.
10 CARTA.
11 Loyd T. (2020, November 12). Moving closer to the problem and closer to the solution. *Stanford Social Innovation Review.*
12 Africa Oxford Initiative. (2020). Shifting the centre of gravity for African science to Africa.
13 AESA has since evolved into the Science for Africa Foundation.
14 Grand Challenges Canada.

REFLECTIONS ON EMBEDDING A DECOLONIAL APPROACH

As well as providing a safe space to advance conversations about coloniality, the organisers also sought to employ a decolonial approach both conceptually and logistically. On reflection, several shortcomings were identified both during and after the series.

- When scheduling the dialogues, we practised equality instead of equity. In doing so, we failed to fully address prior criticism that much of the virtual discussion has taken place at times that exclude those in the Asia-Pacific region; the earlier of our two discussions still took place after working hours for participants in Australia. New Zealand, and the Pacific Islands. This meant that vital voices and experiences from settler colonies were missing.

- This is a nuanced and, at times, contentious debate. The changing roster of participants was valuable for bringing in new perspectives and topics but perhaps hindered the ability to build the degree of familiarity and depth of trust required to really interrogate some of the thornier topics.

- Despite the steps we took to bring new perspectives to the debate and to bring in stakeholders representing the breadth of the global health ecosystem, there was still a heavy focus on academia and a sense that we were preaching to the converted. We need to find ways to draw in the myriad actors that constitute global health and to engage with dissenting voices.

MOVING FORWARD

The previous section provides a selection of potential paths forward, demonstrating that the shift from rhetoric to action is well underway. As more individuals, organisations, and systems reckon with the need for change, additional opportunities and possibilities will present themselves. These are some avenues for exploration which emerged from the series.

1. Acknowledge the contemporary nature of coloniality and colonialism.

While many former colonies have gained independence, the forces of coloniality remain well and alive. In some instances, physical colonialism remains a reality; in others, legacies of colonialism have fed into new mechanisms of coloniality *vis a vis* neocolonialism. In many respects, global health is an extractive endeavour, visible across the ecosystem from unequal research partnerships to the reliance on the labour of un- and low-paid health workers. Existing modes of recognition shape and maintain inequitable structures by rewarding behaviours and practices that uphold the status quo. Redesigning reward structures within global health to acknowledge and incentivise constructively disruptive behaviour can be one of several starting points toward systemic change.

2. Look beyond the global health terrain to tackle the bigger picture.

Beyond a historical understanding of the intertwined roots of colonialism and global health, those seeking significant and lasting change must 'zoom out' of global health to see the bigger picture it sits within: an increasingly complex and polarised social, political, and economic environment. Barriers to change and determinants of the status quo go beyond considerations of well-being to take into account political and economic factors; solutions must do the same.

3. Bridge divides along geographical, societal, and sectoral lines.

Explicitly interdisciplinary, global health is ultimately an implementation-driven field which seeks to create equitable improvements in health for all. Robust collaboration between practitioners, activists, researchers, and funders is needed to move forward as a coalition of complementary actions rather than a movement of fragmented sectors, with particular emphasis on the inclusion, support, and empowerment of actors traditionally marginalised due to geographic and social discrimination such as civil society actors from the global South and marginalised communities.

Whilst the movements in their current iteration have recently found themselves under the spotlight, the goal of a decolonial global health is not new to many working on the ground and across the globe. It is crucial that we identify, acknowledge, and build on the successes of other actors in this space and other decolonising movements.

4. Reimagine collective development as one guided by agency and equity.

Development aid continues to serve as a major driver of global health advocacy, research, and practice, but the coloniality of power dynamics between countries has led to considerable criticism of funding that comes "with strings attached", often to enable the imposition of an external agenda upon local communities. To transform development aid from a tool for dependency to a resource for growth, novel approaches such as Global Public Investment, fair share, and other models of equitable funding must be viewed as part of a larger collaborative effort to decolonise global health.

5. Seek out new voices — both cooperative and critical.

While the aim of this series of dialogues to create a safe space meant that participants were limited to "a coalition of the willing", there is value in identifying and engaging with other actors open to debate and change – those who are yet unconvinced, but not unwilling. Criticism of pathways to change does not necessarily signal reluctance to change, but potentially constructive feedback to improve and expand upon the movements to decolonise global health. Ultimately, the task of decolonising global health is long and arduous, requiring sustained engagement with new voices, new ideas, and new experiences.

NEXT STEPS FOR THE ORGANISERS

United Nations University's International Institute for Global Health

Building on its unique position as a think tank within the UN ecosystem, UNU-IIGH has launched a programme of work dedicated to *Decolonising Global Health* (15) which aims to both continue these dialogues through its convening function and catalyse action through its evidence-to-policy pipeline. This first set of dialogues serves as a foundation from which UNU-IIGH is taking its cues to identify sites of change ripe for a shift from rhetoric to action. *Decolonising Global Health* has begun this work by interrogating the coloniality of knowledge production as perpetuated by universities, think tanks, and journals, as well as exploring the role of private philanthropic funders. Furthermore, recognising the urgent need to progress beyond rhetoric, UNU-IIGH continues to develop, embed, and refine approaches to applying a decolonial lens to all its work.

Development Reimagined

Building on the decolonisation discourse with further dialogues around systemic change, with a focus on more equitable, sustainable financing mechanisms and promoting decolonial collaboration in post-colonial states – at both local and national levels – to challenge existing power structures.

Wilton Park

Wilton Park exists to bring people together to engage on critical global issues, and to advance conversations that are challenges and sometimes contentious. The Shifting Power in Global Health Series highlighted the importance of creating space in which people with different views and experiences can come together and openly explore these and find common ground on how to advance not only the discourse, but the actions towards decolonising global health. Acknowledging the cross-cutting nature of these discussions, Wilton Park is embedding many of the issues and themes that emerged in this series within its global health dialogues, while also engaging directly on how best to support the shift from rhetoric to action.

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15 Decolonising Global Health.

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If you'd like to know more about the "Shifting power in global health" dialogue series or to explore opportunities for continued discussion or collaboration, please contact:

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