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How Can Global Health Institutions Join the Decoloniality Movement?

Embedding and Enacting Decolonial Perspectives in ISGlobal

An ISGlobal policy paper

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CONTENTS

INTRODUCTION

Decolonization has become a buzzword in Global Health circles in recent times, catalyzed by the debates that followed the 'Rhodes Must Fall Movement', the killing of George Floyd, the 'Black Lives Matter' demonstrations, and the health inequities and vaccine nationalisms that emerged during the Covid-19 pandemic. As it often happens with concepts that become popular, usage of the term 'decolonization' has now extended to many forms of **challenging the status quo** in the economic, cultural, academic, and global health spheres. Thus, the term risks becoming a 'creep concept' that brings together numerous issues surrounding equity and justice in the relationship between peoples and countries within the Global North and between the Global North and South.

To situate the intended goal of embedding and enacting decolonial perspectives in ISGlobal, I begin this Brief with an exercise of **conceptual clarification surrounding colonialism and decolonization** (section 1) before focusing on **the existence of coloniality in the Global Health space** (section 2). This will be followed by an outline of **an agenda for decolonization for institutions** like ISGlobal and concluding remarks in response to Richard Horton's cautions against decolonization.

SECTION 1:
Conceptual Unpacking

[This section is taken from Atuire & Rutazibwa [2021], *An African Reading of the Covid-19 Pandemic and the Stakes of Decolonization.*]

Colonization or colonialism is usually understood as a 'flag-planting' exercise of formally (legally and politically) taking over someone else's land and the people and resources in it. From this understanding, it may appear that we are speaking about something in the past because most territories have been formally returned to the previously colonized people. The term POST-COLONIAL is then used to literally mean the period after formal colonization, hinting that it is something that is behind us.

A seemingly subtly different way to engage this is through the unhyphened concept of the **postcolonial**, to point at the fact that, while this period might be behind us, its effects are so profound that there is no way to make sense of the present without engaging with the consequences of colonialism. So, in a way, it is a pushback against the idea that the colonial is in the past, on the contrary, it is very much in the present.

Close to this argument, but a stronger assertion, is the concept of **neo-colonialism**. Coined by Kwame Nkrumah of Ghana in the 1960s, [1] it speaks to the fact that in the post-colonial moment, we do not only deal with just the consequences of a colonial past, but also with the continuation and reproduction —albeit more covertly— of the structures and relations of extraction, dispossession, and imposition between the former colonizers and the colonized peoples. What is more, the colonizing practices and institutions of the flag-planting days, are continued by national and economic elites. This reinforces the fact that for the majority of the previously colonized peoples, the conditions of colonization persist, even in the absence of the White colonizer. Colonization models are thus perpetuated by fellow citizens, former colonizers, and other external actors, as well as through institutions of global governance.

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The concept of **coloniality** as developed by Latin American decolonial thinkers captures this idea most usefully. It is a way to engage colonialism in the present and anywhere (internally, bilaterally, globally) as a (re)production of extreme power inequality and the different institutions created to perpetuate this. These power relations both sanction and invisibilise how they produce premature death, violence against and destruction of peoples and their life, environment, and knowledges. As such, coloniality has been described by decolonial scholars like de Sousa Santos [2] as a triple destructive force of **ecocide**, **epistemicide**, and **genocide**, respectively the killing/destruction of life environments including all the non-human species; knowledges and ways of sense-making; and peoples.

These different ways of understanding colonization mean that **decolonization** is not simply fighting formal imposition or flag-planting, or erasing traces of the colonial past, but very much the more subtle continuations of exploitation, extraction, dispossession, and imposition of one particular —projected as universal— way of knowing, doing politics and governance, organizing our economies, including health and healthcare systems. So, decolonization is then both about attending to the very concrete material

aspects of coloniality (ecocide, genocide) as well as the immaterial ones: the violences, impositions and dispossessions of our knowledge systems and ways of sense making (epistemicide). This means attending to the reality of a global health system that, principally, is epistemically and economically owned, driven, and governed by a single very narrowly defined —claimed "Western" (whereas in fact it is a result of millennia global conversations and cross-fertilization)— framework. This health system which is proclaimed superior and universal generates a dependency of the former colonized on resources that are in the hands of actors —governments and private companies— that are not accountable to persons living within the former colonized territories. Decolonization means actively **retrieving and cultivating agency in health and healthcare**, including unearthing erased and delegitimized health systems.

Decolonization is then about both de-silencing those knowledges and de-mythologizing some of the falsehoods around Western superiority, as well as notions of so-called aid and dependency in North-South relations. Equally, if not more importantly, decolonization is not just about inclusion and diversifying knowledges and participants (that is a minimum but insufficient condition), but very much **about a radical rethinking and distribution of power** at the service of repair and redress, and the radical re-imagination of global and local relations wedded to a will-to-life rather than a will-to-power.

Finally, another way to engage decolonization is to ask why colonization is morally unacceptable? Colonization often comes with injustice, oppression, pilfering of resources, racism, and other evils. Yet, these evils can also occur in situations that we would not normally describe as colonization. Communities within countries may become victims of these evils without necessarily being described as colonized. Also, colonized people can still feel morally wronged even when none of the above-listed evils are more prevalent in their communities than others. According to M. Renzo, colonialism is wrong because it "undermines the capacity of political communities to exercise their self-determining agency in a particular way. When political communities are treated in this way, they suffer a distinctive wrong, independently of whether this treatment is accompanied by any of the other crimes listed above." [3] Thus, from a health perspective, formerly colonized countries as a political community will remain colonized for as long as their **self-determining agency in healthcare** is undermined by the agency of powers that lie outside their borders and are beyond their control.

The task of decolonization is one of recovering and exercising that self-determining agency that has long been undermined. Decolonization means actively retrieving and cultivating agency in health and healthcare, including unearthing erased and delegitimized health systems. In this vein, health and healthcare decolonization means not only equitable access to existing healthcare resources, but also taking the step further to become **generators of health knowledge and resources that can contribute to global health**.

SECTION 2:
Decolonization in Global Health

"If decolonization is about addressing the specific moral wrong of colonization — the subtraction and substitution of agency—, then the decolonization of global health must focus on restoring what was subtracted and enabling what was distorted."

Global Health as a discipline emerged from tropical medicine and international health. Definitions of global health are conditioned by who defines global health and towards what ends. A commonly used definition that can serve our purposes is 'an area for study, research, and practice that places a priority on **improving health and achieving equity in health for all people worldwide**. Global health emphasizes transnational health issues, determinants, and solutions'. [4]

Embedded in this definition is not only the question of improving health for all people worldwide but doing so in a way that is equitable and thus, respectful of the agency of all stakeholders. From this viewpoint, global health has an intrinsically **ethical dimension** whereby ethics is not to be understood only from the viewpoint of individual choices and actions, but also from structural forms of justice and injustice. Given that colonialism and coloniality play an important role in the structures that govern the world, engaging with global health necessarily requires engaging with coloniality. An example is the fact that whereas global health institutions try to resolve health challenges found mostly in the Global South, **the powers, knowledge, and drivers are found in the Global North**. [5]

If decolonization is about addressing the specific moral wrong of colonization — the subtraction and substitution of agency—, then the decolonization of global health must focus on restoring what was subtracted and enabling what was distorted.

Different frameworks have been proposed for advancing a decolonial agenda in Global Health. For example, Atuire & Bull [6] suggest a three-pronged approach of hegemonic, epistemic, and commitmental decolonization. Another approach is to ask where knowledge in global health is being generated [7] and who holds power. Regarding knowledge, Pratt and De Vries offer a tripartite account of epistemic justice that is useful for actors and institutions to self-interrogate about the extent to which coloniality is present in their structures, choices, and actions. Speaking about global health ethics, they ask, who is producing ethics knowledge; what theories and concepts are being applied to produce ethics knowledge; and whose voices are sought, recorded, and used to generate ethics knowledge?

SECTION 3:
An Agenda for Decolonization

Drawing on these and other sources, I propose an approach to embedding decolonial perspectives within ISGlobal. I have generated a grid that members of ISGlobal could use as **a self-interrogation guide** to think through how to enhance an agenda of decolonization. I recommend that the tool be a deliberative dialogue instrument to acknowledge positive achievements and to discuss specific steps that the Institute can take.

The tool is organized as a grid. The vertical side presents the framework of coloniality according to the three keywords described above: epistemicide, ecocide, and genocide. The horizontal side of the grid combines ideas from Atuire & Bull and Pratt & De Vries to generate **three spheres of action** in an effort to enhance an agenda of decolonization. The three spheres are hegemony/power, abolitionism, and commitmentalism.

"This tool is not exhaustive; it is meant to trigger a process of reflection that can lead to change. This form of change can be incremental and gradual with measurable objectives."

- **Hegemony/Power** examines and deals with issues of control, disempowerment, and dependency. In thinking about hegemony, we are invited to examine issues of power and empowerment with the goal of achieving a more equitable distribution of power among stakeholders, especially those whose power has been subtracted through colonialism.
- The **abolitionist** approach is about asking what attitudes, actions, and positionalities which entrench coloniality ought to be discontinued. We often think of change as a matter of doing something. Abolitionism invites us to think about change in a different way, that is, discontinuing what is detrimental to the pursuit of desired ends.
- Finally, **commitmentalism**, means making a conscious effort to go beyond the status quo to foster the ends desired. This may require going out of our comfort zone to engage with new stakeholders and ideas, and to some extent, making ourselves more vulnerable and accountable to a wider range of audiences.

The tool is not exhaustive; it is meant to trigger a process of reflection that can lead to change. This form of change can be incremental and gradual with measurable objectives.

TABLE 1. A draft framework for thinking about decoloniality, justice, and equity. Change can be incremental and gradual.

COLONIALITY/ DECOLONIALITY	HEGEMONY/ POWER	ABOLITIONISM	COMMITMENTALISM
EPISTEMICIDE	What knowledge, whose knowledge, whose voices are included in the academic and research programmes? How is credit for academic output attributed (publications, titles, awards, IP)?	What concepts have we inherited that speak to colonialism and white supremacy (language, terms like *tropical medicine, third world, capacity building*) should we drop? What forms of epistemic violence are we practicing that need to be curbed?	What knowledge and which voices should we actively seek to include in our programmes? What types of uncomfortable inclusion and sharing of knowledge are we willing to accommodate? What forms of inclusion can we factor into our academic outputs to ensure equity in recognizing the contributions of less powerful persons and groups?
ECOCIDE	How does the business model of our institution feed into systems that reduce populations in the periphery to working and serving the centres of power? How green are our spaces, working and traveling habits? What sort of accountability towards the populations we want to serve in Global Health is included in our praxis?	When was the last time we reviewed and discontinued/modified relationships with our partnerships, suppliers, etc. through a lens that promotes greater equity and ecological awareness?	What policies can we adopt to avert our work from feeding into models that impoverish peoples and communities that have historically been marginalized?
GENOCIDE	Who holds power in our organization? How is this linked to morally insignificant (biological) categories?	Which groups of people does our system of selection (staff and students) systematically exclude, and how can we stop that?	How can we actively ensure that marginalized persons (gender, race, religion) are included not only numerically but meaningfully in our spaces?

Source: Caesar Atuire.

SECTION 4:
Concluding Remarks

It has been argued that decolonizing global health is a myth. In the words of *The Lancet's Richard Horton*, "the project of decolonising global health possesses a tragic flaw. For when an Empire falls, it does so only to be replaced by another Empire, one often more insidious and dangerous than its predecessor. The idea that one can purge global health of colonialism is a comforting but deceptive myth". [8] More recently, Horton cautioned against the excesses of decolonizers by comparing them with progressives whose introspection is leaning towards an "internal obliteration" that is "now unfolding in global health." He cautions the global health community against missing "the larger story of just who our opponents really are —those trying to destroy the conditions for achieving the right to health, equity, liberty, and social justice. For **the real enemies of the values we stand for** do not sit within the ranks of global health. They are to be found in governments that instinctively mistrust —and who wish to undermine and defund— global organisations. They will be found among those who demonise refugees. They are the climate sceptics, anti-vaxxers, and purveyors of scientific misinformation. They are those who attack the redistribution of wealth, those who believe that war brings peace, and those who defend racism under the guise of patriotism". [9]

Horton's point is that decolonizers are chipping away at global health in ways that could lead to weakening the good that global health has so far achieved and distract attention from the real opponents of the goals of equity that global health pursues. Whilst there is a good deal of truth and sense in what Horton says, there is also an insidious fallacy in his argumentation which he tries cover with an appeal to pragmatism. The good that global health has achieved cannot be taken as a blanket to cover those spaces of **structural and actual injustice within the global health space**. And this is what decolonizers are pointing at. Secondly, whilst it may be true that excessive introspection can lead to inaction, it is also worth paraphrasing Socrates' idea that 'an unexamined life is deprived of meaning and purpose of existence.' Thus, calls to decolonial calls to examine the theoretical assumptions and praxis of global health need not be a threat to the flourishing of global health. What is more, it is arguable that only **a robust, equitable, and truly inclusive global health space** will be strong enough to defeat those opponents he recommends we focus our attention on.

"The good that global health has achieved cannot be taken as a blanket to cover those spaces of structural and actual injustice within the global health space. And this is what decolonizers are pointing at."

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