



Decolonising global health in 2021: a roadmap to move from rhetoric to reform

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Decolonising global health was a hot topic in 2020. It was the subject of more than 50 academic articles between January and December 2020, appeared as a new area covered in numerous conferences, and featured in public statements by leaders of global health organisations.

Although its aims have not been formally defined, we see ‘decolonising global health’ as a movement that fights against ingrained systems of dominance and power in the work to improve the health of populations, whether this occurs between countries, including between previously colonising and plundered nations, and within countries, for example the privileging of what Connell calls research-based knowledge formation over the lived experience of people themselves.^{1 2} It is well documented—although often overlooked—that global health has evolved from colonial and tropical medicine, which were ‘designed to control colonised populations and make political and economic exploitation by European and North American powers easier’.³ The operations of many organisations active in global health thus perpetuate the very power imbalances they claim to rectify, through colonial and extractive attitudes, and policies and practices that concentrate resources, expertise, data and branding within high-income country (HIC) institutions.^{4 5}

As a group of global health practitioners from different backgrounds, we reflect on our personal and professional experiences of systems and processes that institutionalise power imbalances. In this article, we propose a roadmap for global health practitioners, like us, who want to see rhetoric turn into reforms, focusing on systemic changes needed in organisations led from HICs. This is important now, because the flurry of statements and virtue signalling in 2020, could, in fact, be counterproductive, if this builds an

impression of commitment that allows the leadership of organisations in HICs to escape accountability. We fully acknowledge that colonial mindsets and systems that perpetuate power imbalances in global health are not confined by geographical boundaries; they are found in organisations based in low/middle-income countries (LMICs) too. While we focus here on one part of the problem and the solution, we encourage individuals and groups in LMICs to challenge the status quo.

We start by laying out the uncomfortable honesty that is needed. Dialogues centred on the notion that all stakeholders are always supportive of the decolonisation agenda can be serious impediments to progress. It is important to acknowledge that there will be conflict and discomfort. People in powerful positions, who have likely benefited from current systems, may be concerned about systemic change, be it overtly or covertly. These acknowledgements are essential for moving forward to more impactful and meaningful discussions in 2021.

Once we acknowledge that there will be supporters and opponents of decolonising global health, it becomes clear that a social justice argument or that increasing diversity of leadership alone will likely be insufficient to initiate widespread reforms that redistribute power or resources. Drawing parallels with the feminist movement, it is often the case that an individual accepts the tenets of feminism, while the individual, at the same time, treats women unfairly. The case for systemic change to enable equality in women’s opportunities to hold leadership positions benefited from an emphasis on the impacts of feminist leadership on the effectiveness of organisations as well; framing the argument only in terms of human rights and justice was not enough for all people and organisations.⁶ Thus, dispelling the myth that

Table 1 Examples of ways in which global health organisations based in high-income countries can perpetuate inequities and systemic changes needed

Example of practice that perpetuates inequities	Example of change needed
<p>Limited participation of LMIC experts and community representatives in the governance structures and advisory bodies of organisations focusing on improving health in LMICs.</p>	<p>The majority of powerful positions on governing bodies and decision-making panels of global health organisations should be held by people with the relevant in-country (or regional) expertise and lived experience of the main health issues, contexts and geographies that the organisation focuses on. Governing bodies should have diversity in thought, gender, social, geographical and ethnic backgrounds. They should be selected transparently with input from stakeholders that the organisation seeks to serve.</p>
<p>Arbitrary choice of interventions or research topics with, little coordination or engagement with people on the receiving end, leading to top-down health programmes that cannot be sustained and can perpetuate inequalities in communities.</p>	<p>Decentralisation of resource allocation and programme design to better engage communities served. Keeping global level staff as technical advisers and coordinators rather than decision-makers, allowing sovereignty of patients and communities while supporting mutual learning. Moving away from a biomedical model of global health programmes towards internalisation and integration of local knowledge, indigenisation of assessments and solutions, and following the lead of the affected communities in the assessment of their problems and the appropriate application of medical and public health evidence to their situations</p>
<p>Typically place European or North American ‘experts’ with minimal experience working in the project setting in leadership positions, with a staffing model that assumes they are able to generate more valuable insights than those with local or indigenous expertise.</p>	<p>Ensure that selections are made on the basis of a range of positive attributes, including a minimum level of local intelligence which can be judged considering factors such as: years living and working in the country or region; knowledge of local language(s); outputs of long-term collaborations.</p>
<p>Staff, offices and other resources are based in high-income countries when they could instead be directing resources and employment opportunities to LMICs.</p>	<p>More equitable geographical concentration of resources—including staff and offices—and decision-making power, reflecting the geographical focus of the organisations’ work.</p>
<p>Funding application evaluation panels without or with limited representation from affected communities or stakeholders in which work will be done; grants awarded without due consideration for partnership ethics.</p>	<p>A wider range of experts should be in decision-making positions for grant evaluations, and assessments should be more transparent; funding agencies should develop and provide frameworks for ethical and equitable partnerships; funding should be conditional on commitment to uphold, and evidence of, ethical and equitable partnership practice.</p>

LMIC, low/middle-income country.

everyone working in global health is focused predominantly on health equity and capacity building will allow us to approach the reforms we are seeking with realistic expectations about barriers, incentives and how to frame the issue. The ‘decolonising global health’ movement may benefit from finding strength in numbers by identifying like-minded allies across other progressive social movements targeting system-wide change based on equity, such as the feminist movements.

With the above in mind, we propose steps that global health practitioners could take to drive reforms.

Step one, identify specific ways in which organisations active in global health play interlinked roles in perpetuating inequity—see illustrative examples in [table 1](#). We recognise that the global health sector is broad, encompassing organisations in the public and private domains. These organisations range from small non-governmental organisations (NGOs) to large transnational bodies. An honest and critical examination of the role each

organisation plays in maintaining asymmetries of power is required.

Step two, publish a clear list of reforms required to decolonise global health practice, so that organisations that are committed to moving beyond statements can better respond to the decolonisation agenda in a more proactive and coordinated way.

Step three, linked to the reforms identified, develop metrics to track the progress of organisations active in global health and transparently share findings via different public channels. Publishing sets of actions and metrics that allow (or force) organisations to monitor progress towards their commitments is crucial for holding them accountable to these commitments.⁷ Transparent reporting of these metrics is a core component of accountability mechanisms that are sorely needed in the global health sector.

Although examples of actions taken to address the practices that perpetuate inequities outlined in [table 1](#)

are scarce, documenting those that do exist is valuable. We highlight two examples to illustrate the types of actions that can be taken by organisations active in global health. First, with respect to the composition of governing bodies, the 20-member Board of The Global Fund mandates representation from NGOs and affected communities, with voting rights.⁸ Second, an example of more equitable geographical concentration of resources by organisations was the relocation of Oxfam International's headquarters to Kenya from the UK in 2014. Executive Director at the time, Winnie Byanyima, said the move reflected the need 'to shift [Oxfam's] centre of leadership and to strengthen Southern voices within its decision-making'.⁹ We emphasise that the impacts of such changes on the decolonising agenda need to be assessed, and this is where metrics are critical.

To achieve the steps outlined in our roadmap, we are calling for an Action to Decolonise Global Health (ActDGH) collective that will work towards driving reforms in organisations headquartered in HICs. We welcome collaboration and contribution to the collective (<http://decolonise.health>). For reforms to be realised, we recognise that global health practitioners must play a role in the cultural transformation needed, whereby an influx of new cultural elements and values enables a shift away from a dominant, colonialist culture in the global health sector that attempts to assimilate other cultures within a Western, ethno-centrist and neoliberal approach to global health practice.

There is an opportunity to build on the momentum of 2020, which has been instrumental in drawing widespread attention to unjust practices in global health. But rhetoric is far easier than reform when power and privilege is at stake. Reform will require not only identifying specific deficiencies within the current global health sector, but also actions to radically change the prevailing systems,¹⁰ so that the organisations that currently dominate global health end up being those that demonstrably address needs of people they claim to serve.

In 2021, we need to see action and evidence of progress.

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