Decolonising global health: where are the Southern voices?

Samuel Oji Oti,1,2 Jabulani Ncayiyana2,3

As evidenced by a plethora of publications, webinars, and social media hashtags, the last year or two have seen an amplification of calls for the decolonisation of global health.1–5 These calls have largely been virtually echoed in the hallways of academic institutions in the Global North such as the London School of Hygiene and Tropical Medicine, Duke University and Harvard University. For reasons which we can only speculate about such as fear of retaliation or feelings of powerlessness, the voices of global health institutions and practitioners based in the Global South have largely been absent amidst the calls for decolonisation.

Nevertheless, the rising wave of discontent with the power imbalances that plague the practice of global health is, without doubt, long overdue. This is even more pertinent and timely given that the COVID-19 pandemic is exacerbating global health inequalities.6 For example, it is no secret that countries in the Global North which account for under 15% of the world’s population have secured for themselves almost half of all COVID-19 vaccine doses that are currently available.7 Some global health practitioners have even gone as far as referring to this blatant power abuse by rich countries as ‘vaccine apartheid’ or ‘vaccine nationalism’.8

Overall, while there is consensus regarding the broad focus of this rising discontent, there are divergent views about the best approaches to achieving the decolonisation of global health. Some proponents have adopted a philosophical approach perhaps seeking to ensure that the decolonisation movement is conceptually and theoretically grounded.8 Others have adopted a more pragmatic approach, for example, calling for a set of actions and metrics to hold global health institutions and practitioners more accountable.9 At the other extreme are those that are sceptical about decolonisation and even cynical about the semantics of the word itself.10

Despite this apparent lack of coherence, it is encouraging that these conversations are even happening at all. Just like in the sphere of technological discovery and innovation, there is almost always a period of chaotic experimentation preceding the emergence of what is known as the ‘dominant design’.11 It is therefore reasonable to anticipate that at some point in the future, the global health decolonisation movement will be characterised by its own dominant design—that is, a coherent set of principles, approaches and tools.

However, for those of us in the Global South who continue to endure the suffocating legacy of colonialism in global health, we simply cannot wait for the emergence of a dominant design. We simply cannot wait for the reimagining and rebuilding of the global health field as has been called for by some of our counterparts in the Global North. Therefore, we have decided to throw ourselves headfirst into the sphere of pragmatic action rather than wait on a dominant design.

Specifically, we have heeded the call to volunteer some of our time to become members of the Panel of Movers under the auspices of the Global Health Decolonisation Movement in...
Therefore, we strongly support GHDM-Africa. We do not need justification or elaborate theoretical grounding to support these principles into actionable recommendations. In our opinion, the pragmatic translation of the fundamental principles of diversity, equity and inclusion in the Global North regarding what they can and must do to decolonise global health.

Nevertheless, we are committed to this movement because we believe that GHDM-Africa’s calls for pragmatic approaches to decolonising global health are grounded in the fundamental principles of diversity, equity and inclusion. In our opinion, the pragmatic translation of these principles into actionable recommendations does not need justification or elaborate theoretical grounding because they embody the essence of human decency. Therefore, we strongly support GHDM-Africa’s practical guidance to global health practitioners and institutions in the Global North regarding what they can and must do to decolonise global health.

Of course, we have no way of guaranteeing that anyone will heed to our calls for pragmatic action, nor do we know for sure that the implementation of such actions will lead to sustainable change. We indeed acknowledge that further thought will need to go into implementing some of the recommendations in GHDM-Africa’s framework. For example, the framework recommends that global health organisations should use holistic review methods when recruiting employees to reduce hiring bias against Africans and other persons who are under-represented in global health. Holistic review methods are not widely used and will require further validation in real-world contexts. We also know that questions will be raised about the effectiveness of some recommendations. For example, will training global health practitioners from the Global North on implicit bias or cultural sensitivity really lead to tangible changes in how they work with their counterparts from the Global South?

Imperfections aside, we believe that GHDM-Africa’s framework will prove its utility to those who are willing to at least embrace the spirit behind it. However, its practicality should not be misconstrued as simplicity. We make
no claims regarding how easy it might be to implement the framework. For example, the framework calls on academic institutions in the Global North to embark on a curriculum renewal drive that incorporates transformative learning and cognitive justice approaches into global health education. This means that global health curricula could include the fundamentals of colonial theory and the sociohistorical impacts of colonialism and coloniality in the developing world. Attempting such radical reform will be no walk in the park. Just like we have seen with the resistance to the inclusion of critical race theory in American schools, we know that there will be resistance to reforming the global health curricula.

Circling back to the central question of this commentary which asks: where are the Global South voices in this burgeoning global health decolonisation movement? Our response is that we are right here. We have chosen the uncertain but necessary path of moving from rhetoric to action. We simply do not have the luxury or privilege to do otherwise. We call on global health practitioners and institutions across the world to join us in this journey.

Twitter Samuel Oji Oti @DrSam_Oti

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REFERENCES