


Is decolonisation sufficient?

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To cite: Contractor SQ, Dasgupta J. Is decolonisation sufficient? *BMJ Global Health* 2022;7:e011564. doi:10.1136/bmjgh-2022-011564

Received 16 December 2022
Accepted 17 December 2022



► <http://dx.doi.org/10.1136/bmjgh-2022-010603>



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INTRODUCTION

Decolonisation in global health has gained prominence as a topic of concern and debate in recent publications, seminars and conferences.¹ Highlighting a range of issues from the colonial origins of the field of ‘tropical medicine’ to the disproportionate impact of erstwhile colonisers on public health knowledge and policy-making, scholars have stressed the fact that decolonisation is necessary and urgent^{2–5} at both the epistemic and ontological levels.¹

However, most scholars construct the issue of decolonisation in terms of a binary between low-income and middle-income countries (LMICs) and high-income countries (HICs) or the global North versus the global South. Only a few, such as Haelewaters *et al*⁶ call for recognising intersectionality associated with working cultures and cultural identities, while Morton *et al*⁷ problematise institutional affiliation as the sole indicator for an author’s identity and positionality, where early career researchers and minority groups may get sidelined. Richardson⁷ and Mogaka and Stewart⁸ caution that researchers in LMICs have mostly trained in the dominant global health institutions and it is unrealistic to expect them to declare independence at this stage.

There is limited reflection on how the project of decolonisation is expected to engage with other axes of power that operate in global health. In India, for instance (which is the context that both authors of this commentary best understand), hierarchical and unequal social systems like caste predate colonisation by centuries and have continued to thrive in the postcolonial era. While there is a recognition that ‘colonial mindsets and systems’ are not restricted by geographical boundaries,⁹ there are casteist (and other oppressive) mindsets and systems that are opportunistically positioned to co-opt decolonising discourse for their own benefit. Unpacking how these systems of power interacted with colonialism, and how they continue to exercise power over global health, is essential to advancing the

decolonisation project towards an emancipatory path.

In this regard, we expected that the recent article by Keshri and Bhaumik¹⁰ would be an important and refreshing contribution to the discourse since it attempts to throw light on in-country power hierarchies (‘feudal structures’) that have played a role in sustaining political colonialism, and argues that diversity, equity and inclusion efforts alone may be insufficient to counter these hierarchies. The framing of the article suggests that it might address actual feudal (and other) structures of power within erstwhile colonies in the discourse of decolonisation.⁸ But to our disappointment, the authors use this terminology only notionally, and continue to make the fatal error of using simplistic binary distinctions of HIC/LMIC actors to make their point.

The authors identify three kinds of actors in the global health ecosystem—those located in HICs with their realm of action in HICs, those located in LMICs with their realm of action in LMICs (but who HICs ‘seek to engage with’), and those located in HICs but with their realm of action in LMICs. It is this third group of actors, according to the authors, who act as the ‘Zamindars of global health’ and are answerable to the ‘crown’. The authors make two gross errors in this classification—first, in basing a classification on location, they depart from their own analysis that recognises the role of local elites in both advancing colonisation and strengthening their own privileged positions. Second, they then single out the last group—actors located in HICs with their realm of action in LMICs as the ‘feudal lords or Zamindars’ of global health, which implicitly exonerates the first two groups from both being answerable to a proverbial ‘crown’, and/or holding sway in global health.

The ‘Zamindars’ of global health, however, are not limited to actors located in HICs (regardless of the colour of their skin), but include those very much within LMICs themselves. By excluding the latter from this ‘distinction’, we exonerate them of their role

in the politics of global health (especially the dubious aspects of it), and relegate them to a more 'local' status. But in reality, in-country 'Zamindars' have largely used colonial strategies and discourses to strengthen their own privileged positions (which predate colonialism) and to jeopardise public health. In this commentary, we attempt to illustrate through examples, how these actors have played a role in shaping health policy and how they have interacted with colonialism—sometimes instrumentalising colonial rhetoric, and at other times opposing it—to sustain the status quo.

HOW LOCAL AND GLOBAL POWER HIERARCHIES INTERACT

In India, the most significant of these social hierarchies is that of caste—an arbitrary system of classifying human beings, based on birth. The caste system has its origins in Hinduism, but it pervades all religious groups in India. Despite decades of affirmative action, educational institutions, academia, medicine, media, the bureaucracy and judiciary as well as civil society are all dominated by those belonging to upper castes. The anxieties of preserving this hierarchy run through policy and programmes, including in interaction with public health and global health.

An example of this is the case of family planning in India. In the early 1900s, global Malthusian concerns around rapidly increasing population led to coercive efforts to curb population growth in the global South. There was fear that the growing population in colonised nations could jeopardise Western control, especially as anticolonial struggles were gaining ground—and this was also what motivated the (then) global health community to see population control as a priority agenda. This anxiety was expressed both as fear as well as a greater good of preserving 'human intellect and freedom' (Frederick Osborne at a 1952 meeting of the Rockefeller Foundation).¹¹ But what is more relevant to the decolonial discourse is that this pressure from the global North translated into similar questions about population 'quality' (determined by caste, religion and ability) in India, which featured in discussions around family planning.

In 1940, for instance, a report commissioned by the Congress Party and authored by the social scientist Radhakamal Mukherjee warned of "the 'gradual predominance of the inferior social strata', urging removal of barriers to intermarriage among upper castes as well as directing birth control propaganda at the rest of population to prevent 'deterioration of the racial make-up'".¹¹ This is one instance in which social elites effectively used a colonial anxiety to further their own hold on Indian society. But it would be remiss to think that they did not also occasionally leverage India's population woes to take an anti-imperialist stand internationally. As Mangala¹² points out, while prime minister Indira Gandhi, at the 1972 conference on the environment in Stockholm, resisted Western pressure to curb industrialisation by

appealing to considerations towards India's poverty and population, within India she resorted to Malthusian population policies and presided over mass forced sterilisations of men belonging to lower-caste and Muslim communities in the name of development and population control.¹² In the context of this article, it is important to remember that both Radhakamal Mukherjee and Indira Gandhi were LMIC actors (one a social scientist, and the other a political leader), working in LMIC countries who instrumentalised colonial and anticolonial rhetoric to the advantage of their caste positions.

A similar pattern can be traced in the case of India's nutrition and food policy. In postindependence India, the recognition of the superiority of animal sources of protein (eggs, milk and meat) and its inclusion in the diet, was systematically erased in favour of vegetarian sources of protein in the name of economics—an analysis by Indian scientists who were themselves vegetarians.¹³ Recently there has been consistent opposition from Dalit ('lower' caste) groups to what are seen as Brahminical ('upper' caste) food practices, within which even the inclusion of eggs in mid-day meals for school children is a topic of debate.¹⁴ NGOs who support the government in providing mid-day meals have refused to provide eggs to poor, protein-deficient children because it goes against their religious beliefs.¹⁵ Criticism of such endeavours invite allegations of using 'clichéd colonial tropes of starving children' (see, for instance, reference 16). What is more, 'scientific' commissions like the EAT Lancet Commission on Food Planet and Health are lauding India's experience to show that a plant-based diet is indeed implementable (see Karpagam's commentary on remarks by Brent Loken of the EAT Forum on the commission's launch in April 2019). As Karpagam¹⁷ rightly critiques 'these false notions only serve the purpose of reinforcing age-old casteist control of food policy-making by the vegetarians of the country, while erasing and criminalising the eating habits of the majority'. How do we analyse these examples from a decolonial perspective, and what lessons from history might we pay heed to?

RETHINKING DECOLONISATION

We use these examples to demonstrate why the conversation on decolonisation is not helpful if it does not examine how colonial power interacted with the power of in-country elites—both in collusion with it and in opposition to it—to ultimately preserve the privileged positions of the elites and often to the detriment of public health. In India, as others^{18 19} have remarked, decolonisation must be combined with de-Brahminisation, if it truly intends to be an emancipatory project. In fact, if it fails to do so, as Manoharan¹⁸ warns, it will end up reinforcing discriminatory dominant discourses that appear marginal to the West, but are in fact central to the lives of those of us who live in erstwhile colonised nations.

As scholars located in India, coming from privileged castes, we must not fail to problematise our own

positions, and what we stand to gain from the decolonisation discourse, whether we are located in India or in the global North or somewhere in-between. Indian academic institutions are notoriously casteist and intellectually biased. This is why, the recommendations of Keshri and Bhaumik¹⁰ that LMIC institutions be funded directly and that methods and methodological standards be set by LMICs, avoiding any qualification of which institutions, which principles and indeed which scientists we intend to hand over the global health baton to, sets warning bells ringing and might even be counter-productive. They are not the only ones to have suggested this. Even while scholars recognise that decolonisation must look beyond geographical boundaries, the haste to provide 'solutions' tends to result in recommending measures that re-emphasise binary North–South distinctions. But just as there were colonial anthropologists and missionaries who came to study India from the North, carrying their own biases while producing knowledge, there are upper caste researchers and doctors who study populations and communities far less privileged than themselves (we ourselves are a part of this system). A check on power and questions of epistemology apply to both instances.

We do not, for an instance, want to suggest that the status quo be maintained—nor that the extraordinary influence that HICs have had and continue to have on setting global standards and on knowledge production makes the enterprise more equitable than it would be, if it was controlled by in-country elites. The control wielded by HIC institutions over resources and knowledge-making cannot be justified. But at the same time, unqualified advocacy of LMIC institutions over HIC ones or LMIC 'traditions' over HIC ones, is not the answer and will only lead to co-optation. We also do not want to undermine indigenous contributions to knowledge making, but the politics underpinning this kind of knowledge production must be examined. In this respect, we can learn some lessons from the co-optation and depoliticisation of the gender discourse in development and in global health, which continues to focus disproportionately on representation over substantive structural change.

The project of decolonisation is not just about contestation over institutions, resources and methodologies, but the politics which lie at the heart of how we imagine society. The instrumental use of anticolonial rhetoric to strengthen regressive nationalist projects is neither new nor specific to global health. Anti-imperialist freedom movements themselves have consisted of complex ideological strands, often at odds with one another and perhaps it is worthwhile to think of different philosophies, assumptions and drivers of decolonisation even within these movements. In global health too, we must further complicate this discourse, especially at a time when anti-imperial discourse has been co-opted in so many ways in so many parts of the world.

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Acknowledgements We acknowledge inputs from Sara Van Belle, Werner Soors and Seye Abimbola, and thank them for their insightful comments. SQC is supported by a PhD fellowship at the Institute of Tropical Medicine, Antwerp, from the Directorate of Development Cooperation, Belgium.

Contributors SQC and JD conceptualised the manuscript, SQC drafted the manuscript with additional inputs from JD. Both authors approved the manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement There are no data in this work.

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