



The feudal structure of global health and its implications for decolonisation

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Global health as a field has its epistemological roots in related fields of tropical medicine and international health.^{1,2} These fields are not only products of colonialism, they also enabled imperialism through the destruction of traditional knowledge and consequent capture of the knowledge ecosystem.²⁻⁴ Efforts to decolonise global health are therefore much needed. Calls to reform global health institutions, global health education, agenda setting, resource allocation, the problem in ‘gaze’ and equitable institutional partnerships have been made.^{1,5-7} Unfortunately, diversity, equity and inclusion (DEI) remains a dominant framing of ongoing discussions on decolonising global health.⁵

Efforts around DEI are indeed necessary—as a part of anti-racism and other social movements promoting inclusiveness of all forms of minorities in decision-making^{8,9}; but they do not effectively address the structural imbalance of power between high-income countries (HICs) and low/middle-income countries (LMICs). To undo the persistence of colonialism in global health, it is necessary to understand how feudal structures helped imperial forces to sustain political colonisation. In this editorial, we highlight the similarities of those feudal structures to the current global health ecosystem, and why DEI efforts alone may only strengthen this feudal structure. Moving forward, dismantling the feudal structure of global health should be a target for efforts to decolonise global health.

THE ORIGINS AND NATURE OF FEUDALISM IN GLOBAL HEALTH

European colonisers manoeuvred existing social hierarchies in colonised nations into varying types of feudal structures to sustain imperialism.¹⁰ Broadly, the model consisted of elites in colonised nations being co-opted by colonisers, given proprietary right of land, produce and people, together with the implicit right to exploit. An example of such colonial feudal administrative structure is the

‘Zamindari’ (land holder) system in British India. ‘Zamindars’ were economic and social elites given the right to collect rent from peasants in return for an annual fee to the ‘Crown’. Owing to their intermediary role, they were in a unique position to maximise their income and scope to expand their land holdings but had no pecuniary interest in developing the land. Through these intermediaries Britain controlled India—a large nation, with diverse cultures and values—for centuries.¹¹

During the colonial period, health facilities were developed in colonised nations with the primary intent of protecting the bureaucracy and military which were needed to sustain the political and economic system.^{12,13} However, all the apex health organisations and knowledge institutions were based in Europe. During this period, there was seamless movement between colonised and colonising countries which necessitated and provided the means to develop the field of tropical medicine and international health.¹²

After gaining political freedom, erstwhile colonies embraced continued free movement of knowledge. In the changed circumstances, the ecosystem metamorphosed into a new feudal structure. A small group of multilateral entities and HIC universities evolved into what we see as the ‘Crown’ which controls the global health (knowledge and practice) ecosystem.¹⁴ Academics and practitioners based in HICs (ie, the new Zamindars of global health) working in and for those institutions continued to have seamless access to erstwhile colonies, but the premise on which they operated had changed. The old colonial Zamindars were based in LMICs; but the new global health Zamindars are in HICs. Social and geographical disconnect between the realm of action and the realm of power is the true essence of colonisation. In the current global health ecosystem, actors can broadly be classified under the following categories:

► Located in HICs, with their realm of action predominantly being HICs. Their

interaction with global health ecosystem is primarily technical/methodological.

- ▶ Located in LMICs, with their realm of action predominantly being LMICs. Their primary portfolio and zone of influence is their respective LMIC. Most do not see themselves as ‘global health’ actors. Their interaction with global health ecosystem is primarily on technical or regional issues, and when ‘global health’ actors based in HICs seek to engage with them as part of international health partnerships.
- ▶ Located in HICs, but their realm of action is predominantly LMICs. They primarily enhance their portfolio of work in LMICs but are answerable to the ‘Crown’.

It is this third group of actors—academics, practitioners and institutions based in HICs—who in our framing, act as the feudal lords or ‘Zamindars’ of global health. They dominate over issue domains, in a certain foreign geographical region. Their influence (if not control) on global, national and subnational priorities, policies and resourcing are operationalised through this feudal structure. This enables continued Euro-American hegemony over knowledge ecosystems. Feudalism is justified through narratives on lack of ‘technical skills’ or ‘subject matter expertise’ and promoting monotheism in epistemology and ontology.⁵ Feudalism is further strengthened by neo-colonial economic systems which provide leverage to HICs over LMICs. To make progress, efforts to decolonise global health must first acknowledge this feudal structure of contemporary global health.

ADDRESSING FEUDALISM IN GLOBAL HEALTH

Although DEI efforts within existing ‘global institutions’ are essential to address inequities, they do not dismantle the feudal structure which enables colonisation.¹⁵ On the contrary, DEI efforts grant ‘Crown’ organisations and institutions in HICs legitimacy. To break the feudal structure of global health, the multitude of global health actors¹⁶ needs to take cognisance of their positionality within the ecosystem. Structural power imbalances between nations, within nations, and among different actors in the feudal system should take the front seat in efforts to decolonise global health. These efforts should continue to harvest learning from the parallel but separate movement to end structural racism globally.

Transnational global health actors have an overarching role to end cultural, economic and psychological colonisation¹⁷: culturally, by ensuring that the development of methods and methodological standards are led by LMIC actors and are reflective of local realities; economically, by ensuring direct funding to LMIC institutions without intermediary (or accompanying) feudal lords; and psychologically, by giving greater accord to the knowledge and technical skills of those on the ground over parachuting feudal lords. On the other hand, LMIC governments must improve the ease of doing science—that is, invest in research, remove techno-legal barriers, increase funding

opportunities for citizens, build research capacities and strengthen local knowledge systems for health.

Due to their unique position in the ecosystem, feudal lords themselves are well placed to contribute towards dismantling feudalism. It is no co-incidence that many leaders of political decolonisation movements were people who gave up assured comforts within the colonial political ecosystem to fight for decolonisation. Feudal lords in global health can significantly contribute to the decolonising movement, if they resolve their moral tussle of being ‘double agents’¹⁸ and harvest their network, influence, and intellect to prevent subjugation of individuals and institutions in LMICs. Actors in LMICs also need to engage more intensively in the global health ecosystem. LMIC actors can start by claiming their rightful leadership of the current movement to decolonise global health.

CONCLUSION

This piece was not easy to write. As individuals working in the global health ecosystem, fraught with feudalism, it has always been a struggle to understand our own positionality, identity and role. While we strive to improve health and well-being in LMICs, we also contribute to strengthening the feudal system—a situation that is fraught with ethical and moral dilemmas. We are involved in this feudal structure too. To reach the ‘promised land’ of a ‘global health [which] looks very different’,⁷ we need to dismantle this feudal structure and change the very nature of global health. This is not going to be easy. Structural change not only scares those who benefit from status quo, but also peripheral actors in the system. There is fear of turbulence, but without addressing this feudal structure, the movement to decolonise global health will die a premature death.

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REFERENCES

- 1 Abimbola S. On the meaning of global health and the role of global health journals. *Int Health* 2018;10:63–5.
- 2 Cameron-Smith A. Strange Bodies and Familiar Spaces: W. J. R. In: *Simpson and the threat of disease in Calcutta and the tropical city, 1880 - 1910*, 2007.
- 3 Kwete X, Tang K, Chen L, *et al*. Decolonizing global health: what should be the target of this movement and where does it lead us? *Glob Health Res Policy* 2022;7:3.
- 4 Gibson ADS. Miasma revisited - the intellectual history of tropical medicine. *Aust Fam Physician* 2009;38:57–9.
- 5 Affun-Adegbulu C, Adegbulu O. Decolonising global (public) health: from Western universalism to global pluriversalities. *BMJ Glob Health* 2020;5:e002947.
- 6 Abimbola S. The foreign gaze: authorship in academic global health. *BMJ Glob Health* 2019;4:e002068.
- 7 Abimbola S, Pai M. Will global health survive its decolonisation? *Lancet* 2020;396:1627–8.
- 8 Olusanya BO. Systemic racism in global health: a personal reflection. *Lancet Glob Health* 2021;9:e1051–2.
- 9 Obasi AI, Barley A, Khan M. Racism in two UK global health institutions. *Lancet* 2022;399:1287–8.
- 10 Alavi H. India: transition from feudalism to colonial capitalism. *J Contemp Asia* 1980;10:359–99.
- 11 Banerjee A, Iyer L. History, institutions, and economic performance: the legacy of colonial land Tenure systems in India. *American Economic Review* 2005;95:1190–213.
- 12 Mushtaq MU. Public health in British India: a brief account of the history of medical services and disease prevention in colonial India. *Indian J Community Med* 2009;34:6–14.
- 13 Garg R, Gupta S. Are we really producing public health experts in India? need for a paradigm shift in postgraduate teaching in community medicine. *Indian J Community Med* 2011;36:93–7.
- 14 Rao PR. Science and technology in independent India: retrospect and prospect. *Current Science* 1998;74:418–32.
- 15 Mogaka Ong'era F, Stewart J, Bukusi E. Why and for whom are we decolonising global health? *Lancet Glob Health* 2021;9:e1359–60.
- 16 Hoffman SJ, Cole CB. Defining the global health system and systematically mapping its network of actors. *Global Health* 2018;14:38.
- 17 Rasheed MA. Navigating the violent process of decolonisation in global health research: a guideline. *Lancet Glob Health* 2021;9:e1640–1.
- 18 Pai M. Double agents in global health: Forbes, 2022. Available: <https://www.forbes.com/sites/madhukarpai/2022/02/06/double-agents-in-global-health/?sh=7924697a1a2e> [Accessed 24 Jun 2022].