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Transforming global health: decoloniality and the human condition

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ABSTRACT

The field of global health is at a pivotal moment of transformation. Decoloniality has emerged as a critical framework to assess and transform the pathologies that mark the field. These pathologies include the inequitable sharing of resources, the power hierarchies that entrench decision-making in institutions largely based in North America and Europe and the general predisposition towards paternalistic and exploitative interactions and exchange between North and South. The energy being generated around this transformative moment is widening circles of participation in the discourse on what transformation should look like in the field. The importance of decoloniality cannot be overstated in driving the transformative agenda. At the same time, the popularity of decoloniality as a critical framework may risk omissions in our understanding of the origins of injustice and the pathways to a new global health. To complement the work being done to decolonise global health, I illustrate how the 'human condition' intersects with the transformative agenda. By human condition, I mean the universal features of humanity that lead to oppression and those that lead to cooperation, unity and a shared humanity.

INTRODUCTION

The celebration of difference will be meaningful only if it opens onto the fundamental question of our time, that of sharing, of the common, of the expansion of our horizon. The weight of history will be there. We must learn to do a better job of carrying it, and of sharing its burden. We are condemned to live not only with what we have produced but also with what we have inherited. Given that we have not completely escaped the spirit of a time dominated by the hierarchization of human types, we will need to work with and against the past to open up a future that can be shared in full and equal dignity. Achile Mbembe.[1]

Reimagining global health requires massive transformation. What is needed is not just a restructuring of relationships between North and South, a major emphasis of decoloniality,[2] but opening our horizons to a wider landscape of knowledge generation and use, and cooperation and concern among peoples.[3 4] The decolonising global health project is part of this overarching program of reimagining and seeks to undercover the root causes of oppression. Coloniality is often characterised as both a supremacy mindset and historically and materially structuring practices of power. Decolonising projects have enriched our understanding of the ways that supremacy operates to perpetuate imbalances.[5 6] Situating present imbalances and inequities in colonial histories has deeply enriched our understanding of the pathologies of the current global order and global health specifically. For example, the concentration of financial resources with former European colonial powers is clearly tied to a history of extractive relationships with the colonies, and these extractive relationships continue in the present day in different forms because of this history. The discourse on decoloniality involves both identifying pathologies and their origins and advancing approaches that attend to equity, representation and mutual cooperation.[7 8]

In this essay, I address one of the risks that has emerged with the popularity of the decolonising project, namely the risk of a totalising gaze. In this case, a decolonial totalising gaze sees the north, western or other geographies, practices and institutions as totally problematic, seeing past the positive to the entirely pathological. A risk of totalising is also seeing past the more stable (ahistorical) pathologies of the human condition and locating the origins of injustice in colonialism alone. By stable pathologies, I am referring to the propensity of humans to seek power, to dominate others or to create separation because of perceived differences. Here, I attend to the features of the human condition that are not captured fully by binaries of oppressor/oppressed[9] or zero-sum notions of power (ie, if you have power, then I do not)[10] so common in the decolonial discourse. I draw from key anticolonial scholars like Memmi and Cesaire who noted that the end of coloniality was not simply the end of power-over through the restructuring of political and institutional conditions, but the transformation of

oppressive falsehoods of racism and otherness that drive these structural conditions.[11 12] Ideas of otherness and 'thingafication', to use Aime Cesaire's term, fed colonisation, perpetuated colonial rule and subjectification of indigenous peoples and was used to justify atrocious injustices. These lines of otherness and thingafication are not unique to colonial histories but have expressions throughout human civilisation. Decoloniality alone does not sufficiently attend to the universal aspects of the human condition and what it will take to erase lines of otherness.

In the following sections, I use two sites where decolonising global health has focused to illustrate the constructive potential of recognising the limits of the decolonising lens and the expansive potential of attending to the features of the human condition that lead to otherness and oneness. The first site is that of knowledge, knowledge systems and knowledge claims. This has been a productive site of analysis to identify dominant knowledge systems and the colonial origins of the spread of ways of knowing that involve the exclusion and marginalisation of particular peoples and perspectives. The second site centres on institutional change. While I engage with these two domains as distinct sites of transformation, there is a constant intersection between the two that could not be ignored.

Knowledge

The epistemic features of decolonial projects involve a critique of systems of knowledge and the structural conditions that produce and reproduce certain sources and types of knowledge over others.[13–15] An epistemic critique requires precision in order to avoid reducing knowledge production to an expression of power-over, a precision that is sometimes lacking in decolonial discourse. We can look to the category of 'western' knowledge to examine this dynamic of reduction and the need for precision. Decolonial projects seek to dismantle or break free from the dominance of western knowledge and corresponding systems of knowledge generation and use.[14 16] Decolonial scholars often characterise the western knowledge system by its emphasis on objectivity, empiricism and a quest for universals.[16] This scholarship often links western knowledge to colonialism as a tool that was used by colonial powers in the project of domination. Along with the control of peoples and resources is a reinforcing control of knowledge and thought. The operating assumption underpinning some decolonial scholarship is that the western knowledge system is a form of domination and control, constraining other ways of knowing. This operating assumption is well substantiated through historical record and persists in many ways in the global health space. This is evident in my home country of Canada, where policies were put in place to deliberately and systematically eliminate indigenous ways of knowing, being and doing.[17] At the same time, erasure and decentering are well documented *within* the societies of colonial powers, where advances in scientific knowledge were at times violently suppressed particularly at the intersection of religion and science. In other words, the control of knowledge systems is multifaceted, with expressions between colonial powers and indigenous peoples, and within the societies of colonial powers. The decolonial scholarship often treats western knowledge as both uncontested within the Global North and as exclusively originating from within Europe (at least during the period when European powers were colonising other regions). The next paragraphs shed light on these two assumptions.

The reduction of western knowledge to a system of domination and specifically to colonialism alone obscures the history of mutual exchange between peoples and the collective development of the scientific enterprise. For example, the quest for objective and universal knowledge is not unique to the west and has been pursued in societies throughout history. In fact, western knowledge was heavily influenced by other places and peoples around the world. We look to the rise of Islam to illustrate the orientation of knowledge systems and the way knowledge has been exchanged. The question of 'universals' is one that has received centuries of attention in the Islamic world.[18] Islam was and remains a system of revelatory knowledge that brings forward claims to universal truth. Islamic scholars have drawn from Quranic teachings to inform the investigation of the natural order of things including material reality. There is a consensus among historians that the advances in the sciences that occurred in the Islamic world greatly influenced advances in thought in Europe leading into the Enlightenment period.[19] Historians attribute the mathematical discipline of algebra to the Persian scholar Muhammad ibn Musa al-Khwarizmi in 800AD.[20] Ibn Sina (aka Avicenna), a prominent Islamic thinker and physician living in the time of 1000AD, created the first encyclopaedia of medicine that was used in Europe for centuries.[21] These examples illustrate that the knowledge that we attribute to colonialism or present western knowledge systems has been informed by innumerable exchanges between peoples.

A more contemporary example of the ways that knowledge is contested not simply through a decolonial lens can be drawn from conversations within the health professions about what types of evidence should inform health practice. For example, there remain debates about the legitimacy of qualitative research in informing health services or programmes.[22 23] Within this discourse, there have been calls to integrate reflexivity, a concept that explicitly 'interrogates interpretative systems' and seeks to uncover the hierarchies of power that structure the types of knowledge that inform practice, into healthcare practice and programmes across country contexts.[24–26] Part of this call is informed by decolonising perspectives,[27] others are rooted in the need to attend to the lived experience of patients, or the generated clinical experience of practitioners.[25] This same dynamic is reflected in the recovery-oriented care movement that in many ways pushed back against the medicalisation of mental distress.[28 29] The recovery-oriented approach although not

monolithic has drawn from the experiences and knowledge of those living with mental illness to foreground systems of health promotion and care that focus on the whole person, recognise how culture shapes the meaning of mental distress and community-oriented and integrated approaches to mental healthcare. Generally, this approach has positioned psychiatric treatment as one of many types of supports required to facilitate quality of life, including the provision of community services, fostering community integration and peer support. Embedded in this movement was a questioning of the validity of psychiatric classifications and the efficacy of psychiatric treatments. For example, scholars have even questioned the core categories underpinning psychiatry and mental healthcare more broadly including what is meant by 'sanity'[30] or whether classifications like depression can be universally applied to explain emotional experience.[31] This type of reflexivity has contributed greatly to weighing different approaches to classification and care in light of factors such as community culture and individual meaning attributed to distress or effective ways to institutionalise or deinstitutionalise care.[24 32 33] The point is that even within disciplines there are debates about which knowledge is legitimate.

The commitment to recentre knowledge that has been pushed to the periphery and expand the sites of knowledge production does not mean we have to reject knowledge and knowledge systems attributed to the colonial period or colonial legacies. The critique of western knowledge systems may be better suited as a critique of hegemonic and dogmatic adherence to one way of generating knowledge. What decolonising global health may inadvertently, or in its more radical forms deliberately, do is restrict itself from the promises and possibilities of knowledge systems that are associated with the 'west' or the 'north', systems that have borrowed and benefited from collective knowledge exchange such as the examples I provided above.

Institutional change

The decolonising project interrogates institutions, particularly the institutions like universities, aid agencies or non-profit organisations based in the global north, as the products of oppressive histories, embedding and perpetuating structural and epistemic injustice, deciding on the fate of others and excluding the other from meaningful participation. This interrogation is a necessary and productive task. The structure itself, having been created by a vision of otherness, including notions of charity that positioned global health as a means for those in the Global North to serve 'developing countries', 'low-income' or some similar categories of persons, has an impact on the way these structures operate. The transformation of editorial boards of global health journals,[34] the emphasis being placed on authorship representation[35 36] and a new ethics of research partnership[37 38] are only a small sample of institutional changes taking place.

There is a delicate and difficult line to tread in seeking to transform current institutions involved in global health. Part of the challenge lies in determining what needs to stay and what needs to be changed. Like the coloniser, the extremes of a decolonial discourse can reflect what Memmi captured so well about the dynamics of otherness: 'The colonialist stresses those things which keep him separate, rather than emphasizing that which might contribute to the foundation of a joint community'.[11] I will turn to Olufemi Taiwo's brilliant and challenging work 'Against Decolonization: Taking African Agency Seriously'[39] to illustrate some of these points about the risks of a totalising decolonial approach (although Taiwo goes much further to call for the elimination of a decolonising approach entirely). Taiwo argues that decolonising scholarship (focusing mostly on the fields of philosophy and social theory) has become too encompassing, attributing problems to colonialism that in his view do not warrant such association. He suggests that this totalising approach has been driven in part by the conflation of colonialism and modernity (eg, democratic forms of governance, advances in technology and science), which he argues should be separated. He advocates for a nuanced disentangling of history in relation to the present in a way that is open to noting the good with the bad. The good in his view being the modern project of scientific advancement and democratic forms of governance, while also rooting his view in the perspective that humanity is 'one'. The latter point is taken up in detail by Taiwo, where he suggests that the decolonising movement has been 'captured' by scholars who use the lens of decoloniality in a purely negative way that seeks to divide and deconstruct and in turn falls into old and new lines of otherness and division. Hellowell and Schwerdtle illustrate this point well in their analysis of the decolonising global health movement where they highlight several arguments in the decolonial discourse that essentialise oppression with the oppressor, further entrenching divisions according to North/South, oppressor/oppressed binaries.[40] Taiwo illustrates this point powerfully in the following reading of Fanon and Cabral (two eminent anti-colonial thinkers) where he notes that "neither Fanon nor Cabral were interested in pedigree because they both knew that transforming the struggle against colonialism into a call for renouncing any aspect of the cultural, social, political, or scientific life of the colonizer would be to give up on the oneness of human—the ultimate racist trope—and the fact that hybridity is the very core of human civilization".[39] (p62) Taiwo is making this point in relation to his broader assertion that "There is a near absolutization of the concept (of colonialism) in the literature such that little care is taken to acknowledge its complexity and historicity, nor to investigate the distinct paths of colonialism and modernity in different parts of the continent (Africa)." (p138) While I do not think that the same can be said, at least not as a broad characterisation, of the whole decolonising global health movement, there are certainly expressions that tend to reduce all the pathologies of global health to an essentially and intentionally oppressive colonial institutional landscape.

Presumably, the challenges we face within institutions associated with global health, in addition to particular problems of power and resource concentration in the Global North, are perennial challenges of power sharing, recognition of

difference, how to consult and make decisions in collaborative ways, and how to foster cooperation within and between institutions. These challenges have origins in supremacy mindsets and historically structured legacies of colonisation. They also have origins in the human condition; the social, psychological and affective dispositions of human beings living with others. We talk about decolonising global health because we harken to colonial histories and patterns that contributed to current structures and practices that perpetuate inequity, asymmetry and marginalisation. This is important. By ignoring the human condition and the tendencies of humans to emphasise and use difference as a barrier to connection, there is a risk of mischaracterising the struggle for equity and justice. One response to difference has been conflicts between tribes, empires and states, while recognising that difference is also actively constructed by those who seek power over another or power within a group by situating themselves in relation to another. This is the response that the decolonising global health movement is pushing back against. The colonial logic of subjectification, racism, marginalisation and control of the so-called 'other' is one approach to difference. However, other notions of difference may see difference as a strength, where different experiences and ideas are seen to help generate advances in the human well-being. Even during the colonial period, there were approaches to difference that sought understanding and mutual exchange, not only domination and control.[41] Even such a fraught period was characterised by advancements in inclusion and expanding collectivity; movements that sought for the fair treatment of workers, the abolition of slavery, the protection and promotion of the rights of women, civil rights and others. The 'peoples' these movement sought to include and protect have expanded over time, where for example, the waves of feminism have expanded the circle of concern to racialised women and other women who had been historically marginalised. Likewise, in the current context, the pursuit of more inclusivity and representation of different groups and perspectives in the institutional environment is one that includes pushing back against colonial legacies, but is also tied to more particular, yet universal, dynamics within institutions, like ensuring that individuals have the space to share their perspectives or how to attend to different perspectives and experiences while operating as a single programme, organisation or institution.

CONCLUSION

The decolonising global health movement is playing an important role in reimagining not only the field of global health, but who participates, the equity of participation, the epistemic appeal to widening the scope of participation to enrich the knowledge relevant to the field, and redressing and reimaging the structural conditions that shape cooperation and partnership, access to resources both for research and practice.[13 42] I suggest that to complement this decolonising work, it is important to identify the features of the human condition that persist; those that require ongoing attention. In an essay on a similar topic, we drew attention to various issues involved in the unreflexive use of the category Low- and Middle-Income Country (LMIC) in research across disciplines and the implications that this can have for reifying notions of us and them.[43] We also extended a suggestion not for the elimination of the category, but its thoughtful and justified use. In some situations, the category may be warranted, in others less so, and in others not at all. We might want to approach decolonisation in a similar way. The colonial impact on structural inequalities particularly in the history of extractive relationships between places and peoples persists and has significant implications for the pursuit of greater equality between countries, regions and peoples. The colonial impact on consciousness, particularly the racist underpinnings used to justify and support colonisation, remains prominent in both the psych and structure of international relations. At the same time, what a narrow decolonising approach might miss is the universal project of navigating difference. Where difference has existed, regardless of geography, there has been prejudice and alienation. This is a universal condition. Even within 'white' or western societies, the grades of whiteness have been judged. The prejudice against eastern Europeans in western European countries continues to be a major fault line dividing peoples.[44] This to say that the broader project is that of establishing harmonious, united, loving societies. Put another way, the broader project of humanity at large is the project of moving from us and them, to us. One version of the decolonial project that risks further division is the one that treats oppressors as static and somehow inherently oriented to oppression. This risk applies not only to individuals but to institutions as well.

The deconstruction of structural and epistemic inequities is a necessary process. So are the aspirational elements, like a system of knowledge exchange that facilitates learning across contexts. The global in global health does not need to remain characterised by rich–poor, north–south, oppressor-oppressed dichotomies. This is the point about reification. These categories can risk missing the richness of existing communities and practices, the local efforts to care for the health of communities in 'low-resource settings' and those with resources.[45] If we widen the gaze to the knowledge that is constantly being generated in communities around the world, we are already growing in our understanding of the human condition and what is possible in the realm of knowledge and care. Again, the asymmetries of power and influence need to be changed; there is no question about this. This project necessarily involves dismantling the conditions that perpetuate asymmetries. Importantly as these conditions fall away, we need to simultaneously build something new; something more just, and as I present in this essay, something that attends to the human condition. The human condition involves the propensity to reduce, other and dominate, as well as the capacity and the potential to connect, to listen, to build together, to share and to sacrifice for another. This project turns each of us inward to recognise what it is within ourselves that risks oppression and what fosters unity, care, compassion and the virtues that foster harmony. It is about taking this inward gaze and extending it outward in

our social and institutional realities. This is an expansive project.

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