SHIFTING THE POWER : A ROAD MAP TO DECOLONISE GLOBAL HEALTH

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Movements such as Black Lives Matter have inspired and energised efforts to improve social justice and address racial inequities. The field of global health – the term used to define efforts of rich nations to improve the health status of low income countries (LICs) – is currently facing the challenge of how to embrace these principles. Historically, global health priorities and agendas have largely been determined by institutions based in or shaped by the Global North, with considerable variability in how much involvement the Global South has been invited to have.

Global health was largely conceptualised in the post-WWII period when technical expertise and "know how" were considered the exclusive domains of high income countries (HICs). The tenets of global health are rooted in colonial tropical medicine, an approach that was formulated during the peak of European colonisation. The goals at the time were primarily to protect the colonisers from the perils of tropical diseases. Little was done to understand and serve the health needs of local populations. This led to inequities being baked into the public health infrastructure in LICs.

This structured power imbalance has energised efforts to decolonise global health. The movement toward decolonisation, sometimes called localisation or shifting the power, is aimed at changing this status quo in which power, influence, resources, and policies that affect the health of LICs reside significantly in HICs rather than in communities in the Global South where they belong. For example, some donors have supported the eradication of diseases through vaccines or the delivery of certain treatments for specific diseases that they

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wish to target within the Global South. During the time that this donor support is provided, human and financial resources within the LICs shift to that disease-specific area rather than to the strengthening of the health sector in general. When the donor moves on to a different health problem area, it can prove difficult for these efforts to be sustained by the LIC. From the funders' perspective, the incentives to continue highly focused health efforts and targeted interventions are much easier to measure impact (eg, number of vaccines distributed or shots in arms) within the finite length of the project. Infrastructure strengthening and the lengthy processes necessary to ensure local leadership and ownership take much longer, don't lend themselves that well to quantifiable metrics, and the timeframe can be way beyond that of a specific project length.

In practical terms, decolonisation can occur when local communities lead the way in determining what health interventions are most needed and how these services should be designed, managed, evaluated, and adapted. We could not find any randomised controlled trials that compared the impact on health of programs implemented using principles of decolonisation versus those that do not. However, for the reasons discussed above, our view is that localisation and all that it implies is essential for sustainable improvements in health and wellbeing that last after external funding ends.

The concept of decolonisation is not unique to the health sector; it is an idea rooted in addressing unequal power imbalances. We believe the diagnosis and the suggested actions below cut across and can be applied widely to various development sectors, but our focus here is on the health sector.

This viewpoint proposes ways that decolonisation and localisation can transition from being an inspiring goal to a fundamental structural change in global health. It is a difficult path and will take time. Among other things, decolonisation requires funders to shift power from themselves to those whose programs they support. Funders who embrace the decolonisation movement recognize this and are already making changes, but will they will go far enough and are they willing to accept the risks that will occur during a period of transition?

What is the importance of decolonisation?

Decolonising global health is the right thing to do on ethical grounds. It is also profoundly practical. Local communities know more about their own needs than do outside experts, and the Global South has a huge, growing reservoir of expertise and lived experience that remains underused. Decolonisation we hope will at least limit, if not eliminate, the situation where donor driven priorities control the agenda in the Global South.

Why is it taking so long?

If decolonisation is the right thing to do, why isn't it happening faster?

Extensive literature on the topic suggests four major reasons, all of which are driven by the control and availability of resources. We note that while this viewpoint focuses on global health, the following reasons apply to all development aid sectors :

1. **Predominance of academic institutions in HICs** that produce and credential global health experts, and publish their research without open access. Research entities and universities in LICs remain the poor relations of their counterparts in the Global North. The majority of research is often published in just English, regardless of where the research took place, further limiting LICs researchers, policy makers, and civil society.
2. **Funding sources** for global health experts to continue their work in both research and implementation comes almost exclusively from the Global North. Financing comes from multi-lateral agencies such as the development banks and the UN health programs; bi-lateral funding (individual HICs supporting health programming in individual LICs); and private philanthropy, most notably the Gates Foundation. These funding sources have also supported the growth of Non-Government Organizations (NGOs), the largest of which are based in HICs, but with many having local offices in LICs.
3. **Systemic barriers faced by Southern experts** because global health financing is largely controlled by HIC institutions. Even when funding and resources from HIC institutions are designated for LICs, HICs receive a greater share of that designation. On top of this, most aid does not pass through local or recipient governments/organizations. Partner country governments, private sector firms, and NGOs combined manage a total of 32% of funds after global aid is divided through the various channels. Aid funding that comes solely from the United States is worse, where only 9% is received and able to

be implemented by recipient country's government, firms, and non-profits. In 2018, only about .01% of the total development assistance, as reported by Official Development Assistance (ODA), went to projects focused on developing local leadership, across various sectors. This percentage was not directed towards improving collective leadership of local communities.

4. **Southern experts often do not receive recognition** outside of their own countries despite their incomparable local knowledge. As a consequence, the design, implementation, and evaluation of global health programs is rarely led by experts from the local communities most impacted. It also has to be said that, in general, Southern experts are paid less than Northern experts despite their specialised skills and nuanced understanding of local needs.

How can we support and accelerate the process?

The following pragmatic actions could make a difference in support of a decolonised and fairer set of relationships in global health and other development sectors for that matter. These suggestions are not in any chronological order but rather they suggest a way to proceed, the details of which will depend on the unique circumstances of individual LICs and local communities.

1. **Express commitment to decolonisation and localisation publicly.** Public facing materials, websites, and grant making procedures of larger multi- and bi-lateral agencies lack specific language around decolonisation. It's not clear if these agencies have concrete plans to change that. Private philanthropies and international NGOs have done better; many have made a public commitment to decolonize their work, and they use a variety of language to express that. For example, Oxfam/Great Britain uses the phrase "shifting decision making power," while others, such as Save the Children, have woven these concepts into their Gender Equality Effort initiative. The Dutch NGO, Mama Cash, uses the term "power sharing," and private philanthropies such as the Hewlett and Packard Foundations have committed to "power shifting." We also recommend removing commonly used language from our vocabulary, such as "providing technical assistance," that is condescending and perpetuates power disparities. Explicit commitments set alongside clear statements of what would be different, and by when, could give more credibility to vague statements of intent.

2. **Turn commitment into action by:**
    - ✓ Putting local experts in charge of teams that design, implement, and evaluate global health programs and remunerating them appropriately.
    - ✓ Providing career paths for local experts that will enable them to work in other LICs and at headquarters and assigning responsibility to make this happen.
    - ✓ Shift the offices of organisations involved in global health as much as possible to the LICs. This transition is already taking place such as the example of Oxfam GB and others moving important functions to the places in the Global South where their work occurs.
    - ✓ Challenging individual and organizational beliefs of power in the Global North
3. **Raise more resources from the Global South**. Realistically, to be sustainable, a meaningful shift in the power imbalance of global health will require moving away from the almost exclusive reliance on Global North financing. Well-resourced individuals, philanthropies, and corporations exist everywhere including in LICs. Initiatives from within the Global South to raise support from these sources would go a long way to increasing local control of global health. This solution supports stronger local accountability of health providers and of those responsible for allocating resources for health.
4. **Make better use of civil society within the Global South**. Civil society organisations (CSOs) can provide the political impetus for their governments to make rational and transparent decisions. Although CSOs cannot replace the role of governments, ideally they can complement and support state efforts. However, it is not easy for grassroots CSOs to influence how global health resources are used in their communities. Many large bi-lateral donors, especially European ones, provide general support to ministries of health in the Global South. In principle, these ministries consult with local CSOs on how to allocate funds. However, based on the writers' experience it remains unclear to what extent they do nor how these ministries act on the input they receive from grassroots organizations.
5. **Recognise and be realistic about the limitations funding agencies have in fully implementing global health decolonisation.** Government funding agencies in rich countries are answerable to politicians and taxpayers. Support for development aid is rarely politically popular and the public remains wary of corruption. Efforts by USAID to provide greater leeway to partners in the Global South have floundered because of laws and policies that tightly regulate how money can be disbursed. Efforts by USAID to localise and decolonise development assistance has primarily focused on helping organisations in LICs better deal with the myriad of rules and regulations inherent in US Government funding rather than looking to Southern Partners to lead the way with their own strategies and implementation priorities. There are current calls to address these government funding policies to better fit the needs of the countries the funding is going to.

Many private philanthropies are taking steps to shift the centre of gravity of their funding to the LICs and some have put in place hiring practices to speed up diversification of their own staff. However, the reality is that private philanthropies still base their funding agenda on their strategies– what they think is important. They've made progress in getting local involvement in executing these strategies, but establishing priorities remains firmly the purview of Global North headquarters. Philanthropies would benefit from some soul searching here. There are encouraging examples, notably MacKenzie Scott, who support the priorities of the grantee and don't try and shift these. We also positively view the approach of trust-based philanthropy which, as its name suggests, involves a somewhat lighter oversight touch towards grantees and is true to the spirit of decolonisation. These changes will enable philanthropy to promote localisation and decolonisation more effectively in their global health funding.

6. **Expedite technology transfer and strengthen scientific research capacities.** The Covid pandemic showed clearly the need for the fast and effective transfer of health technologies to LICs. While there is disagreement among experts about the pros and cons of patent protections, there appears to be a growing consensus that medical research centres located in LICs need to reach their full potential. The global benefits that will accrue once this situation is transformed are many and profound. Health research led by LIC institutions is more likely to reflect the priorities of the region, the LIC diaspora of scientists would have meaningful work to return to, and local populations would no longer always be at the back of the queue as far as their own health needs are concerned. Progress has begun to achieve these goals and needs to be reinforced and sped up.

7. **Increase representation of experts from LICs on the boards of funding agencies.** While some internationally-based experts originating from the Global South are on the boards of funding agencies, there is generally a lack of governance representation from experts who choose to remain in their local communities. 75% of board seats are held by representatives from HICs, 51% of which are held by U.S. and U.K. representation. We believe that this absence impedes decolonisation efforts.

8. **Improve SRHR vocabulary itself to reflect the cultural complexities of these issues within the various geographies of the Global South.** For example, if one speaks for the Indian subcontinent, the LGBTQI concept itself is foreign and has colonial underpinnings. It alienates and stigmatises. The subcontinent historically had local terms and a rather spiritual view of transgender people and was much more tolerant and inclusive of those with diverse sexual desires. Decolonisation of aid must also include decolonisation of language .

Actions and Existing Models for Creating Genuine Partnerships

Democratising institutions of global health and development, such as the World Bank, UN system, or the various multilateral health partnerships that have developed over the last two decades, will aid governance and be a good start in ensuring Global South countries have a stronger voice. Models such as the Global Fund for AIDS, Tuberculosis, and Malaria demonstrate existing governance solutions with the potential to ensure that Global South countries and CSOs can influence decision making and policy. The AmplifyChange pooled fund for sexual and reproductive health and rights (SRHR) offers a good model whereby civil society entities based in LICs manage and disburse grant funds directly and bypass local power elites.

We encourage efforts to move the headquarters of these entities to the Global South. Policies that have already been put in place by donors and NGOs to shift power should be evaluated by experts from both the Global North and South, and the lessons learned widely shared.

Final Thoughts

Decolonisation is not a technical issue. The international aid system is political, as is everything when it comes to power relations. We would like to see greater political awareness of and commitment to the actions needed to make decolonisation a reality. Clearly, leadership and governance are still predominantly shaped by the Global North. We hope that the decolonisation movement will lead to genuine representation at all levels of governance, advisory boards, and institutional arrangements for delivery by people with lived experience from countries on the issues of concern. We believe that the actions and approaches outlined above will help speed the decolonisation process. It is not often that the right thing to do is also the most practical and impactful, but in the case of decolonisation, all of these goals can be reached and by so doing health for all will benefit.

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