



## The art of medicine

### Will global health survive its decolonisation?

There are growing calls to decolonise global health. This process is only just beginning. But what would success look like? Will global health survive its decolonisation? This is a question that fills us with imagination. It is a question that makes us reflect on what Martin Luther King Jr saw when he said in 1968, in the last speech he gave before he was killed, that “I’ve been to the mountaintop...and I’ve seen the Promised Land.” If what he saw was an equal, inclusive, and diverse world without a hint of supremacy, then, that world is still elusive. Similarly, an equal, inclusive, just, and diverse global health architecture without a hint of supremacy is not global health as we know it today.

What we know as global health today emerged as an enabler of European colonisation of much of the rest of the world. It has since taken on different forms—for example, colonial medicine, missionary medicine, tropical medicine, and international health—but it is yet to shed its colonial origins and structures. Even today, global health is neither global nor diverse. More leaders of global health organisations are alumni of Harvard than are women from low-income and middle-income countries (LMICs). Global health remains much too centred on individuals and agencies in high-income countries (HICs).

A future in which global health is decolonised would be one in which there are no longer pervasive supremacist remnants of colonisation within global health practice. But how do we imagine such a world? The calls for equity and justice in global health practice need to be matched with a bold vision of the future. What vision can global health practitioners rally around and work towards? As the struggle for equity and justice continues, those in power are likely to fight back—or respond with evasions, token concessions, and changes in appearance but not in substance. Perhaps, a clear vision of what equity and justice looks like can help global health practitioners overcome such inadequate responses.

To decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level. Supremacy is not restricted to White supremacy or male domination. It concerns what happens not only between people from HICs and LMICs but also what happens between groups and individuals within HICs and within LMICs. Supremacy is there, glaringly, in how global health organisations operate, who runs them, where they are located, who holds the purse strings, who sets the agenda, and whose views, histories, and knowledge are taken seriously. Supremacy is seen in

persisting disregard for local and Indigenous knowledge, pretence of knowledge, refusal to learn from places and people too often deemed “inferior”, and failure to see that there are many ways of being and doing. Supremacy is there in persisting colonial and imperialist (European and otherwise) attitudes, in stark and disguised racism, White supremacy, White saviourism, and displays of class, caste, religious, and ethnic superiority, in the acquiescing tolerance for extractive capitalism, patriarchy, and much more.

Indeed, supremacy persists in the ways of seeing and assumptions that underpin global health practice. It is a supremacist way of seeing and doing when we entertain implicit hierarchical assumptions—for example, about the headquarters of a global health organisation being more important than its regional or country offices. Supremacy manifests in seeing the big as superior to the small—for example, in the focus on national governments when subnational governments are more consequential and closer to the ground. And supremacy is enacted when a greater value is placed on research by HIC or distant experts than the knowledge of those with lived experience.

Will global health survive its decolonisation? Perhaps. But only if its practitioners commit to its true transformation. A crucial first step is recognising that ours is a discipline that holds within itself a deep contradiction—global health was birthed in supremacy, but its mission is to reduce or eliminate inequities globally. To transcend its origins, global health must



Martin Luther King Jr (1929–68)

become actively anti-supremacist, and also anti-oppressionist and anti-racist. Equity and justice involve flipping every axis of supremacy on its head.

The supremacy that manifests in global health is not peculiar to global health. Entrenched in the fibre of past and present social and political systems, supremacy re-creates the inequities that global health seeks to undo. It also generates funding, jobs, and training opportunities in global health. But rather than re-enact and reflect the world back to itself in the fullness of entrenched oppression, global health must offer the world a better version of itself. Global health must free itself from the persisting blindness of supremacy and embrace its alternative—equity and justice.

In the promised land that we imagine, academic global health looks very different. Imbalance in authorship within partnerships between HICs and LMICs is a thing of the past. Journals have been transformed. Knowledge platforms are now decentralised and democratised. No longer exclusive, high-impact western journals now exist among a multitude of go-to places, most of which are now based in the Global South. In our reimagined world, the traditional mindset in global health—that expertise flows from HICs to LMICs—is a thing of the past. Many academic institutions in the Global South are as influential as those in the Global North—with a clear mission to serve the disadvantaged across both settings. There is no dependence, only mutual learning. Trainees from HICs are eager to study global health in LMICs to learn directly from experts who are closest to the problems and closest to the solutions. Global health degrees are accessible to those who need them the most and are taught by those who are at the front lines.

It is a different world. Reports of racism in global health organisations are a thing of the past. These organisations are no longer White-led, White-dominated institutions in HICs but have reoriented their operations to be closer and accountable to the people they serve. They are run by people who are local to the issues and local knowledge takes pre-eminence. Governed inclusively and responsively, these organisations now focus on organic change, as allies and enablers of local processes and learning. Rather than seeing global health as charity or saviourism, they seek to push for health as a fundamental human right, locally and globally.

In this imagined future, global health practitioners in HICs and those who are otherwise privileged, have embraced an appropriately modest view of their importance, and mastered the art of critical allyship, where they see their primary role as allies and enablers rather than leaders. Rather than drawing from a limited talent pool of elite HIC institutions, Black, Indigenous, and other people of colour are the real leaders of global

health. In particular, women in the Global South, who form the majority of the global health workforce, are proportionately represented in leadership.

In this future that we can barely see, diversity and inclusiveness are not enough. The focus is not only on things that can be easily measured, but also on things that matter but cannot be easily counted—for example, how new voices are heard and prioritised and how the people who now make the field diverse go about reshaping it for the better. In this imagined world, representation is as important as how it alters the agenda; what is on the table is as important as who is around the table. It is a landscape that serves the most disadvantaged and recognises that you cannot truly help or support people, be their allies and enablers, without seeing the world through their eyes and seeing yourself as they see you. The imaginative leap that allows a global health practitioner to consider their position or an issue from varying viewpoints requires respect and humility. Empathy is not enough. The desire to make the world a better place, however genuine and heartfelt, is not enough. Respect and humility are vaccines against supremacy.

It is a future that we can only dream of. This vision is a mere start—a sketch of a dream—an invitation for others to join us, to dream more vividly, and to chart a path to making such a dream a reality. We see many young global health practitioners who share these dreams. They are not afraid to ask uncomfortable questions. Established global health practitioners, including us, must do better, even if it means “leaning out” to make space for young and minoritised leaders who are better positioned to imagine global health anew.

Will global health survive its decolonisation? Well, if the future of global health is more of the same with some cosmetic changes to disguise supremacy, it would have failed. But if the future is a radical transformation, then global health would be unrecognisable. We may even have to give it a new name. The goal of global health should not be to survive its decolonisation, but to rise up and live up to the pressing demands of its mission. The reality of Martin Luther King Jr’s dream of a just and equal world would not have been any different. It is a different world, a different global health.

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## Undoing supremacy in global health will require more than decolonisation

I read with interest Seye Abimbola and Madhukar Pai's Perspective.<sup>1</sup> It provides an enlightening and hopeful vision of decolonised global health detangled from supremacy in its many forms. However, it left me feeling that the vast mark that colonisation has left on society, politics, and system hierarchy within low-income and middle-income countries (LMICs) has been less considered. Without paying due consideration to the challenges of supremacy and oppression within LMICs, we cannot realistically equalise global health and progress to ensure that it upholds health equity and social justice.

Globally, we observe how rich academics in high-income countries (HICs), particularly from the UK and USA, tend to get richer. For example, the ways in which global health funding and publication are dominated by prominent academics and high-income prestigious institutions mean that worthy work can be dismissed when teams are less valued. Importantly, many individuals from LMICs who are valuable

in directing global health endeavours do not have the opportunities or training to prove why or how they are valuable in meaningful ways to academia. Under some circumstances, they can be actively oppressed.

There is a refusal to learn from local populations, especially those from the margins of society, and ethnic superiority exists within societal, political, and academic structures in both HICs and LMICs, which is rising amid right-wing conservatism in some settings. How do we effectively empower valuable leaders to push forward necessary global health measures when they are restricted from the outset?

Colonisation has left a pervasive mark. Its legacy in LMICs still needs to be unpicked. Creating truly equitable global health must involve diverse groups of people who view challenges through differing lenses from their backgrounds, lived experiences, and skills, and who have wider, inclusive visions that do not focus on individual career success and are not at the mercy of prescribed academic agendas in HICs.

I declare no competing interests.

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- 1 Abimbola S, Pai M. Will global health survive its decolonisation? *Lancet* 2020; **396**: 1627–28.

Seye Abimbola and Madhukar Pai<sup>1</sup> describe eloquently how, for historical reasons, global health is operationalised as a saviourism model. To redress the balance of power between saviour and saved, they envision a utopic global health fuelled by respect and humility, and motivated by an adherence to values based on rights, equity, and justice.

Unfortunately, the disciplines that dominate global health attend to the causes of and solutions to disease endpoints on the health and wellbeing spectrum. Such disciplines have not engaged adequately with a crucial understanding of the sociostructural

production of health or with the political arguments based on myriad values that fall outside of the traditional medical and health sciences. It is impossible to decolonise global health if crucial geopolitical analyses, and the impact on relationships between high-income countries (HICs) and low-income and middle-income countries (LMICs), remain chronically marginalised.

Additionally, decolonising global health extends beyond relations between LMICs and HICs; it is also about the relationships within them. Decolonisation is fundamentally about redressing inequity and power imbalance. It cannot be achieved without also addressing gender inequity, racism, and other forms of structural violence. The colonised also have to be at least as reflective about the status quo as the colonisers. This mindset goes beyond engagement and participation between HICs and LMICs, to disrupting the norms of dependency within LMICs that enable the inequities and replicate the hierarchies of neocolonialism. In real terms, LMICs must confront their own internal power relations inherent in the discourse of immutable culture, which protect cronyism, tribalism, poor governance, and patriarchy.

Ultimately, a decolonised global health can only exist within a broader geopolitical and economic environment that supports rights, equity, and justice.

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### Authors' reply

We thank Keerti Gedela as well as Pascale Allotey and Daniel Reidpath for their responses to our Perspective on decolonising global health.<sup>1</sup> We welcome and completely agree with the points they highlighted for additional emphasis: greater

focus on the local dynamics of how supremacy creates health (in)equity within countries, and expansion of our disciplinary focus to include research methods to understand how the geopolitics of supremacy creates health (in)equity between countries and to incorporate the knowledge held by the intended beneficiaries of global health efforts.

As we emphasised,<sup>1</sup> colonialism and power asymmetry between high-income countries (HICs) and low-income and middle-income countries (LMICs) is but one manifestation of supremacy. Therefore, undoing supremacy will require much more than decolonisation. Nevertheless, decolonisation is a good place to start given its role in the creation of global health, and how coloniality persists in the field. The structures of supremacy and oppression that manifest between countries are reflected within countries in the supremacist institutions of, for example, class, racism, casteism, and patriarchy. Although the historical origins and underlying philosophy and rationale of these institutions might differ, they are similar in how they oppress and maintain inequities in (the circumstances that create) health. In addition to national spaces, oppressive power relations of supremacy are writ large in intranational spaces too.

To understand how geopolitics perpetuate inequities and how incorporating local knowledge can help to reduce inequities in global health, we must undo another important supremacy in the field—ie, the disciplinary supremacy that places the quantitative biomedical and epidemiological sciences (often led by HICs) above the qualitative political and anthropological sciences.<sup>2</sup> One of the many great lessons of the COVID-19 pandemic is that achieving equity in (the circumstances that create) health is at least as much a domain of the political and anthropological sciences as it is one of the biomedical and epidemiological sciences. This lesson is relevant within

HICs and LMICs, as it is in global and international affairs.

Ultimately, as both Correspondences highlight, the locus of the change we seek in global health is within not only HICs but also LMICs. In research partnerships or funding decisions, it is not enough that HIC actors lean out.<sup>3</sup> LMIC actors must also lean in—eg, by calling out parachute research, demanding reciprocity, setting up their own high-impact academic journals, or building high-quality schools of public health. However, doing so requires funding and political action, which national and international power relations might obstruct, but against which we must fight because combating all forms of supremacy should be synonymous with global health.

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## Osteoarthritis in 2020 and beyond

We applaud the bold move of creating the *Lancet* Commission on Osteoarthritis, an often forgotten illness.<sup>1</sup> Globally applicable and acceptable solutions need transdisciplinary action, which the Commission has clearly thought about, given its diverse professional make-up. In this line of thought, we would like to highlight two other *Lancet* Commissions, the *Lancet* Commission on Global Surgery

and the ongoing *Lancet* Commission on Diagnostics.<sup>2</sup>

Total hip arthroplasty is considered one of the most successful and cost-effective surgical interventions ever developed.<sup>3</sup> Furthermore, even though the mantra we treat patients and not x-rays remains a core value in orthopaedic surgery, treating patients with osteoarthritis without access to diagnostics is near to impossible. Despite the benefits of diagnostics, economic constraints in low-income and middle-income countries severely restrict access to surgical care and diagnostic technology.<sup>2,4</sup> We believe that the work done by the *Lancet* Commission on Global Surgery and the *Lancet* Commission on Diagnostics can meaningfully inform the work of the *Lancet* Commission on Osteoarthritis.

Additionally, we would like to ask the commissioners to consider inviting a paediatrician or paediatric (orthopaedic) surgeon to further the transdisciplinary nature of the Commission. Such an expert could provide valuable insights on paediatric conditions that predispose osteoarthritis, such as scoliosis, developmental dysplasia of the hip, Legg-Calvé-Perthes disease, or septic arthritis, and possible pathways for prevention and mitigation.<sup>5</sup>

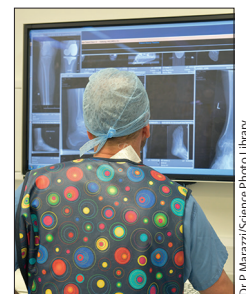
We wish the commissioners all the best in their important work, and we hope that they are willing to consider our reflections and suggestions.

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For the *Lancet* Commission on Global Surgery see <https://www.thelancet.com/commissions/global-surgery>