Forming a Coalition of The Willing to Decolonise Global Health

– *Is it possible, what impact could it have, and what next?*

Report by Development Reimagined

May 2021

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Glossary

In order to clarify key terminology used in this report we have provided a glossary of terms. Although different definitions may be used by others, Development Reimagined has chosen to use these definitions when exploring this topic.

Biomedicine – The Western-originated global standard medical practice system of scientifically-backed methods and treatments (surgery, medication, human resource allocation, and care).

Build Back Better – A digital campaign set up by Green New Deal UK and supported by a coalition of multiple NGOs and CSOs from diverse sectors; working towards a COVID-19 response that asks governments to improve on existing systems and adhere more honestly to the Sustainable Development Goals.

Black Lives Matter (BLM) – A social movement that highlights systemic inequality and violence against black persons globally; started in 2013 as a social media hashtag.

Colonialism – A form of domination/control by individuals or a group (country) over the territory and/or behaviour of other individuals or group (country).

Decolonisation – The dismantling of unjust colonial-rooted methods, biases, and systems to ensure the independence and full agency of all involved organisations, communities, and persons.

Donor Organisations – The larger international global health organisations that operate in LMICs, better funded with longer reach capacity; usually offer funding to/partner with implementing partner organisations.

Global Health Organisations – The organisations of varied sizes and focus areas, ultimately focused on development or humanitarian work in the global health sector.

HICs – High Income Countries.

Horizontal interventions – Health interventions that are "delivered through public financed health systems and are commonly referred to as comprehensive primary care"; these involve broader interventions across multiple interconnected issues.

Implementing Partner/grass-roots Organisations – Smaller, locally-based global health organisations that operate in LMICs with less funding and reach capacity in comparison to large international organisations.

Intellectual Property (IP) – Defined as creations of the mind, such as inventions; literary and artistic works; designs; symbols, names, and images used in commerce.[1] In a global health context, IP typically relates to patents for designs for drugs, medicines, and medical equipment.

LMICs – Low and Middle-Income Countries.

Neo-colonialism – A class system for all policies, infrastructures, and agents actively contributing to society which indirectly perpetuate colonial-era practices and behaviours.

POC – Person/People of Colour – terminology for any person who is not considered "white".

White Gaze – The assumption that "whiteness" is the default human state and is the standard measure of advancement, whereas non-whiteness is implied to be a deviation from the normal.

Vertical interventions – Health projects that are "delivered with a selected target area for intervention" and do not require integration in the local healthcare systems, and may involve global or national procurement in another jurisdiction that is not the local delivery point. Examples may include anti-malaria bed-nets to COVID-19 vaccines.

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[1] See: https://www.wipo.int/about-ip/en/

CHAPTER ONE: INTRODUCTION

In the wake of COVID-19 and the Black Lives Matter movement, it has become evident that the global health sector is plagued by problems of prejudice and power. Reports of harassment and discrimination in some of the world's largest health and humanitarian aid organisations have emerged on various media outlets[2] and the narrative of expected failure in terms of how low-income countries have responded to COVID-19, in particular in Africa, has been proven incorrect, yet persistent as a result of racism.[3]

However, the COVID-19 pandemic offers an important opportunity to deconstruct and refine the power and processes that go into global health. In line with the "Build Back Better" campaign, there has been a renewed emphasis on global health stakeholders to challenge and confront the inequalities of power, the removal of the "white gaze", and the encouragement of local ownership.

The link between the BLM (Black Lives Matter) movement, Decolonisation, and COVID-19

The BLM movement[4] – which began as a social media hashtag in 2013 and persists today as an important social movement, speaks against police brutality and systemic racism against Black persons globally. It also serves to highlight the wider systemic inequalities faced by persons in low and middle-income countries (LMICs), most of which were colonised states prior to gaining their independence.

In the past, colonisation served to entrench harmful, extractive systems that served the (mostly) Western powers and not the colonised people. Post-independence, most colonised people went on to build nation states using governance and legal templates created by their former colonisers[5] - and joined a global system still led by old colonial powers - further perpetuating the inequality on a global scale. Such unequal systems can prove deadly when they extend into the health sector, such as when

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2 See public references to organisations such as Medecins Sans Frontieres (MSF), Department for International Development (DFID, now Foreign Commonwealth and Development Office, FCDO), USAID; International Committee of the Red Cross, World Health Organisation (WHO), Danish Refugee Council, Mercy Corps, and more in these links: https://www.theguardian.com/global-development/2020/jul/10/medecins-sans-frontieres-institutionally-racist-medical-charity-colonialism-white-supremacy-msf; https://www.telegraph.co.uk/politics/2020/08/26/racism-endemic-dfid-leaked-report-claims/; https://www.nbcnews.com/politics/politics-news/usaid-staff-demand-action-agency-leaders-over-systemic-racism-n1230316; https://www.dw.com/en/un-health-organization-to-investigate-racism-misconduct-allegations/a-47130306; https://www.reuters.com/article/us-global-racism-humanitarian-exclusive-idUSKCN24F0CB.

3 Powell, A. (2020, November). *Africa Spared Worst of Pandemic by 'Coordinated, Collaborative' Approach*. Voice of America. https://www.voanews.com/covid-19-pandemic/africa-spared-worst-pandemic-coordinated-collaborative-approach.

4 *HUSL Library: A Brief History of Civil Rights in the United States: The Black Lives Matter Movement*. (n.d.). Howard University Law Library. https://library.law.howard.edu/civilrightshistory/BLM.

5 BETTS, R. (2012). Decolonization: A brief history of the word. In BOGAERTS E. & RABEN R. (Eds.), Beyond Empire and Nation: The Decolonization of African and Asian societies, 1930s-1970s (pp. 23-38). Brill. Retrieved May 2, 2021, from http://www.jstor.org/stable/10.1163/j.ctt1w8h2zm.5.

doctors misdiagnose based on race[6] or when COVID-19 vaccine production and disbursement choices favour richer nations.[7]

Global health as a field has historical ties to European colonial endeavours and interests.[8] Indeed, the names of certain organisations that remain at the centre of the global health sector such as the London School of Hygiene and Tropical Medicine (LSHTM) hark back to this age.[9] However, the shift from the early mission of protecting colonisers from disease to the modern goal of improving health equity worldwide indicates how far the field has come. Despite this shift, however, in many cases the old structures persist and steer the agenda-setting, decision-making capacity, and prioritisation of proceedings for health initiatives in LMICs around the world.

From past to present: **Localisation, Diversity and Inclusion, and Decolonising Global Health**

Today, global health is often characterised by the partnerships between LMICs that were previously colonised and several high-income countries (HICs) that were colonisers or legitimised slavery and apartheid systems. The partnerships are focused on health, however, they often also fit within the "development" and "humanitarian" sectors. The development sector in particular is meant to prioritise four principles of "development effectiveness", one of which is "country ownership" or localisation.[10] However, and while this report will not delve into the details or practicalities of this principle, it is worth noting that in 2019, according to a monitoring report by the GPEDC Secretariat: "*The alignment of the development partner projects to partner country objectives, results indicators, statistics, and monitoring systems is declining".*[11]

Similarly, while discussions initiated by academics, activists, and health practitioners have been ongoing for years, a robust effort to decolonise global health is only now currently emerging, directed towards minimising the long-standing power imbalances in the global health arena by considering both the direct legacy of the colonial era and the structures that are still in place.[12] For example, there are questions around who gets unfettered access to global health institutions, knowledge production in terms of who shapes and leads the research delivered in LMICs, and the international organisations that control the levers of power in the context of public health agenda-setting in each project. There has been some renewed emphasis in global health organisations on increasing diversity and inclusion (also known as the D&I agenda). Nevertheless, while these actions are crucial, welcome and need to continue, as this report will illustrate, they are haphazard, have few (if any) targets for monitoring progress, and uncoordinated.

To date, no development organisation – whether practicing or advisory – has come up with a simple, engaging framework to ensure global health organisations can and do take a holistic approach to solving these issues and ensure progress can be tracked globally. Hence, this report, which aims to take up this urgent need and opportunity.

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6 Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academies Press (US).

7 Growing global Covid vaccine inequity 'grotesque', says WHO. (2021, March). France24. https://www.france24.com/en/health/20210322-covid-19-who-slams-grotesque-growing-global-vaccine-inequity

8 Saha, S., Kavattur, P., & Goheer, A. (2019, April 26). *The C-Word: Tackling the enduring legacy of colonialism in global health*. Health Systems Global. https://healthsystemsglobal.org/news/the-c-word-tackling-the-enduring-legacy-of-colonialism-in-global-health/

9 LSTMED. Decolonising global health: colonial history & institutional structures that perpetuate disadvantage. https://www.lstmed.ac.uk/news-events/seminars-and-lectures/decolonising-global-health-colonial-history-institutional

10 See: https://www.effectivecooperation.org/landing-page/effectiveness-principles

11 See Page 21: https://www.effectivecooperation.org/system/files/2019-09/Global%20Partnership%20Monitoring%20Progress%20Report%202019_Part%20II.pdf

12 Leon-Himmelstine, C., & Pinet, M. (2020, June 3). *How can Covid-19 be the catalyst to decolonise development research?* From Poverty to Power. https://oxfamblogs.org/fp2p/how-can-covid-19-be-the-catalyst-to-decolonise-development-research/

CHAPTER TWO: AIM AND OBJECTIVES OF THIS REPORT

This report and the project it is derived from aims to fill a gap by examining and proposing a holistic framework for global health organisations working in Africa, and by extension other LMICs, to take concrete steps towards decolonisation. The framework is intended for use by senior management teams and boards of the global health organisations. It is based on the collection of interviews, surveys, and policy dialogues and driven by the stakeholders that took part in the various consultations described below, including a self-reported survey and rounds of dialogue.

The framework aims to formulate ideas for solutions and recommendations that will guide stakeholders when it comes to interrogating and shifting systems of power—global, national, local, interpersonal, and institutional in global health projects. In this sense, the report aims to provide the basis for a practical, solutions-oriented "coalition of the willing" to tackle decolonisation in global health to go forward, make change, track progress, and inspire others to join the coalition and create long-lasting solutions across the sector.

Methodology of this report:

The data and information used in this report was collected through three major methods: a literature review; an anonymised survey, and individual/combined dialogues **(Figure 1).**

Figure 1: Overview of the methodology of the project
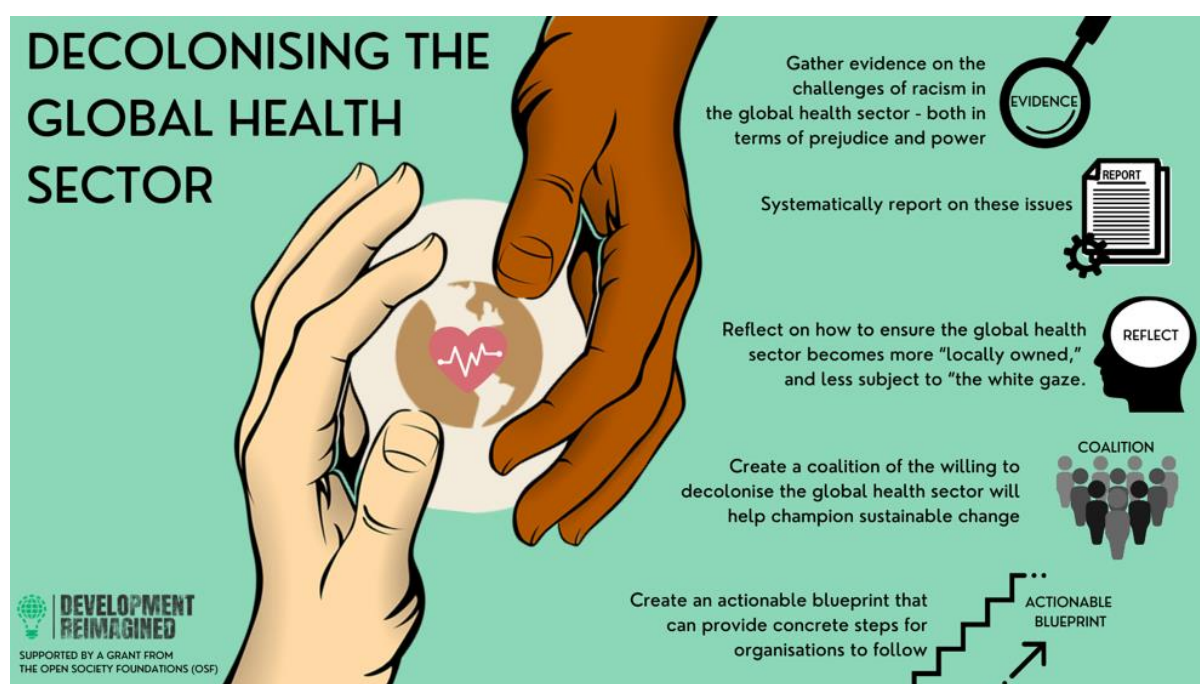
Source: Development Reimagined

Evidence Review:

The report analysed around 200 documents, including journal articles, newspaper extracts, conference minutes, and press releases from a range of global health organisations dating from 2000-2020. Around 60 documents the team at Development Reimagined found most useful, have been included in the evidence review and referenced in this document.

It was important to embed as much diverse literature as possible to gather a more nuanced understanding of the challenges. Importantly, the evidence review provided an opportunity to understand the current challenges and gaps in action, and explore a potential new framework that could be validated through other aspects of the methodology.

Anonymised Survey:

A comprehensive online survey was designed to gather evidence of the key challenges that global health organisations and implementing/local partners face with regard to prejudice and power. The survey – attached at **Annex I** – consisted of 46 questions and primarily focused on gathering the views of local implementing partners with a focus on African partners. The survey was distributed to over 70 organisations through direct emails and on social media platforms, including Twitter and LinkedIn, with an explicit request that senior representatives in the organisations complete the survey. The organisations included a mixture of both grass-roots implementing partners and larger global health organisations headquartered in Europe and North America. From the responses received (32 in total), the organisations confirmed that they were involved in funding, product procurement, research & development (R&D), health policy, and implementation of health projects in LMICs.

The evidence gathered from the surveys formed the basis of discussion for the dialogues and helped provide recommendations for this report.

Interviews and Policy Dialogues:

10 semi-structured interviews were conducted with leading global health experts, along with senior personnel from global health organisations to guide the scope of the research. This enabled a focus of research on the more prominent challenges that were not previously addressed.

Two policy dialogues, organised towards the completion of this report, were held in order to consolidate the themes extracted from the research, survey, and interviews and zeroed in on the specific solutions that the organisations were/are implementing in this area. The dialogues were held virtually on 25th March and 15th April 2021, followed Chatham House rules,[13] and were limited to representatives from around 8-10 different organisations per dialogue to ensure open and flowing discussions. The stakeholders were invited on the basis of the scoping research and included a mixture of donors, project implementers, domestic and international civil society organisations, and researchers working in the global health sector. Additionally, there were representatives from the organisations based in LMICs and those headquartered in HICs.

The premise behind the policy dialogues was to present the preliminary findings from the interviews and the survey results to the stakeholders and explore recommendations and actions. In this respect, the dialogues were designed to ensure reflection on whether the organisations faced similar problems identified in the evidence review, interviews and survey results. It was also an opportunity to gain a better understanding of where each organisation was internally when it came to decolonising and the best approaches that worked well for them. Thus, and perhaps more important than simply discussing problems of racism and prejudice in the sector, the policy dialogues were aimed at formulating solutions. **Figure 2** below shows the guiding questions that were used for the policy dialogues.

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[13] In which points made and information disclosed during a meeting may be reported by those present, but the source of the points or information may not be explicitly or implicitly identified. This report therefore also adheres to this rule.

Figure 2: The guiding questions for the dialogues

Q1: What initiatives has your organization developed – or would like to – to overcome some of the challenges discussed in the survey?

Q2: What initiatives are working – and what isn't working? Are your staff, management, donors or partners supportive?

Q3: Have your organization's operations changed due to COVID-19? Has the pandemic supported or hindered your decolonization efforts?

Q4: How can we best work together in the global health ecosystem to drive decolonization? What mechanisms are needed?

Source: Development Reimagined

Organisation of this Report:

As we, Development Reimagined, embarked on the evidence review in particular, we began to see five main areas or themes of challenges. The themes were somewhat connected but distinct, and their combination began to highlight more clearly the structural imbalances and racism prevalent in the global health sector. Thus, we have organised this report based on these five key themes, as shown in **Figure 3.**

Figure 3: Five Key Themes for the Decolonisation Process in Global Health
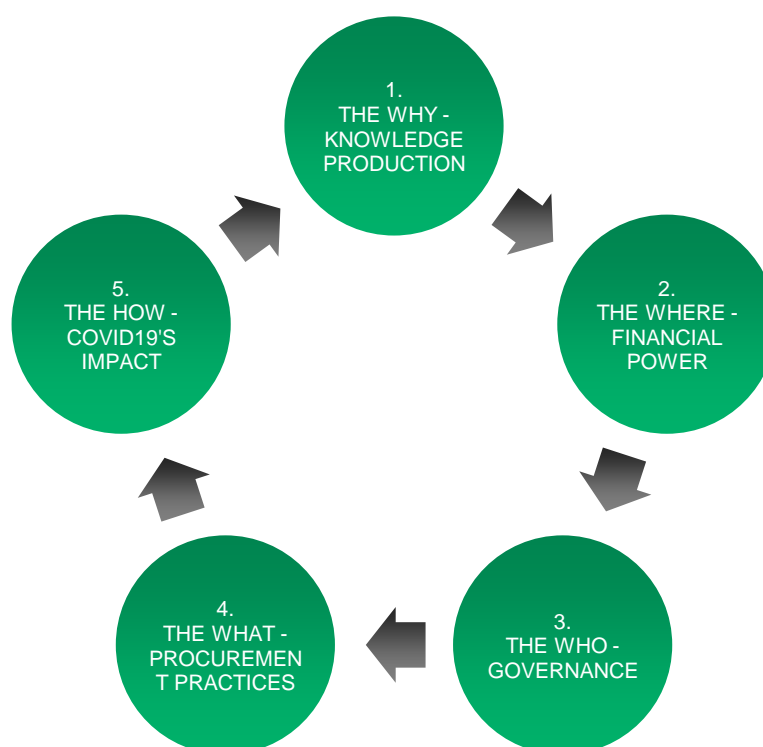
Source: Development Reimagined

CHAPTER THREE: CHALLENGING DECOLONISATION, A PRACTICAL GUIDE

This chapter explores the key literature, reflections from the survey, and policy dialogues based on the five key themes identified in Chapter Two. It also includes case studies gathered during the dialogues and scoping research to inspire organisations to envision the change needed, as practical solutions.

Theme One: The WHY - Knowledge production in Global Health

One of the consistent themes in decolonising global health is the manner in which knowledge in global health is generated. The strategy behind the current construction of global health knowledge is one that is built on the asymmetrical power relationships between researchers from the HICs and those directly involved in global health projects, usually persons in LMICs.

For instance, Western biomedicine is still considered as the most legitimate method of generating and applying knowledge in the health sector,[14] in comparison to other medicines and cultural treatments, whether from China, India, African Countries, Latin American, or the Caribbean islands.[15] Decolonising global health requires a critical interrogation of the assumptions, addressing the structural inequalities that exist within the institutional stakeholders that operate in this field, and challenging the long-standing conscious and unconscious biases.[16]

The COVID-19 pandemic has also highlighted the need for contextually sensitive knowledge production. For example, there has been documented evidence of the positive impact of co-produced research when it comes to sharing power from the start to the end of projects; a pertinent example being the recent engagement and co-production of research from Germany, Hong Kong, Lebanon, and Pakistan in response to the COVID-19 crisis.[17]

Knowledge production is also linked to the *way* research is collected in LMICs, with emphasis on who collects the research and who ultimately receives the recognition: the issue of authorship is of major concern in the global health sector. There is increasing evidence that researchers from LMICs do not receive adequate recognition for their contributions to research, whether in data collection, qualitative analysis or writing[18] as recognition is often reserved to researchers from HICs.[19] This has had important

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[14] Carrie, H., Mackey, T. K., & Laird, S. N. (2015). Integrating traditional indigenous medicine and western biomedicine into health systems: a review of Nicaraguan health policies and miskitu health services. *International journal for equity in health*, *14*, 129. https://doi.org/10.1186/s12939-015-0260-1

[15] Ibeneme, S., Eni, G., Ezuma, A., & Fortwengel, G. (2017). Roads to Health in Developing Countries: Understanding the Intersection of Culture and Healing. Current therapeutic research, clinical and experimental, 86, 13–18. https://doi.org/10.1016/j.curtheres.2017.03.001

[16] Büyüm, A. M., Kenney, C., Koris, A., Mkumba, L., & Raveendran, Y. (2020). Decolonising global health: if not now, when? *BMJ Global Health*, *5*(8), e003394. https://doi.org/10.1136/bmjgh-2020-003394

[17] Marten, R., El-Jardali, F., Hafeez, A., Hanefeld, J., Leung, G. M., & Ghaffar, A. (2021). Co-producing the covid-19 response in Germany, Hong Kong, Lebanon, and Pakistan. BMJ, n243. **https://doi.org/10.1136/bmj.n243**

[18] Pai, M. (2019, November 21). Lack of equity and diversity still plague global health research. *The Conversation*. https://theconversation.com/lack-of-equity-and-diversity-still-plague-global-health-research-127239

[19] Abimbola, S. (2019). The foreign gaze: authorship in academic global health. BMJ Global Health, 4(5), e002068. https://doi.org/10.1136/bmjgh-2019-002068

implications on the direction of the research and future funding for the researchers from LMICs. A recent example being the case of Jean-Jacques Muyembe, the Congolese doctor who was the first to investigate the Ebola outbreak in 1976. Yet, he only recently received international co-recognition for the feat in 2019[20]; while the discovery is still mostly credited to Peter Piot, the Belgian virologist who isolated the virus from samples sent by Muyembe.[21]

The sentiment was also apparent in our survey, with many of the grass-roots organisations echoing the same concern. Analysis from the survey revealed the disparities in the frequency of receiving leading authorship between donor and implementing organisations, with around 41% of the organisations surveyed "rarely" or "sometimes" credited with lead authorship (**Figure 4**). On the other hand, the answers of donor organisations or those not directly involved in the project implementation were 100% "always" or "most times" credited. This presence of a power differential in global health research has further been corroborated by a recent document which extracted papers on 'health' in sub-Saharan Africa published on PubMed between 2014 and 2016. The results showed that of the 7,100 articles identified, only around 50% of the publications had a first author publisher who was originally from the country of focus.[22]

Figure 4: Receiving credit for lead authorship – How often?
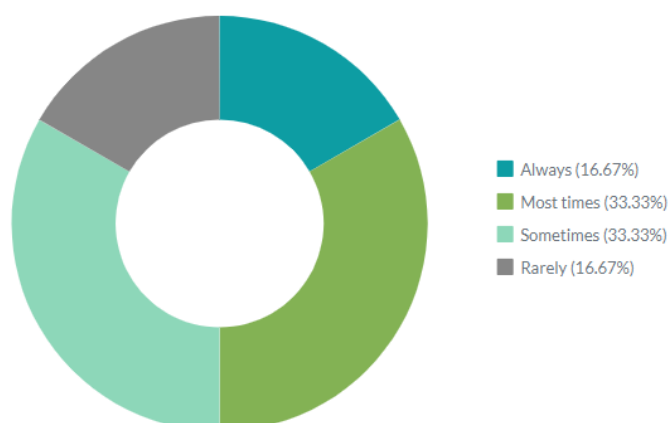
The premise behind the growing concern in relation to authorship is ultimately a palpable proxy for issues tied to power asymmetries in relation to the production of knowledge in global health. It is important to note that this is not an issue of authorship in a vacuum, but places importance on deconstructing the origins of the power imbalances that influence whose authorship is *valued*.

The challenges concerning representation in the global health arena are not only limited to authorship and local partners' leadership, but extends to conference location and attendees. **Figure 5** illustrates the challenges, showing that of the global health conferences analysed in a BMJ study [23], only 4% were

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[20] Peralta, E. (2019, November 4). *This Congolese Doctor Discovered Ebola But Never Got Credit For It — Until Now.* NPR. https://www.npr.org/sections/goatsandsoda/2019/11/04/774863495/this-congolese-doctor-discovered-ebola-but-never-got-credit-for-it-until-now

[21] World Health Organisation. (2018). Jean-Jacques Muyembe Tamfum: a life's work on Ebola. *Bulletin of the World Health Organization*, *96*(12), 804–805. https://doi.org/10.2471/blt.18.031218

[22] Hedt-Gauthier, B. L., Jeufack, H. M., Neufeld, N. H., Alem, A., Sauer, S., Odhiambo, J., Boum, Y., Shuchman, M., & Volmink, J. (2019). Stuck in the middle: a systematic review of authorship in collaborative health research in Africa, 2014–2016. *BMJ Global Health*, *4*(5), e001853. https://doi.org/10.1136/bmjgh-2019-001853

[23] Velin, L., Lartigue, J. W., Johnson, S. A., Zorigtbaatar, A., Kanmounye, U. S., Truche, P., & Joseph, M. N. (2021). Conference equity in global health: a systematic review of factors impacting LMIC representation at global health conferences. *BMJ global health*, *6*(1), e003455. https://doi.org/10.1136/bmjgh-2020-003455

held in LMICs, and less than half of attendees were from LMICs. This is highly problematic – as it shuts off access to power and influence for those who know the most about local health challenges.

Figure 5: LMIC representation at global health conferences[21]

Of 112 conferences hosted, only 4 were held in LMICs

Of 98,302 disclosed attendees, only 38,167 were from LMICs

4%
96%

28%
72%
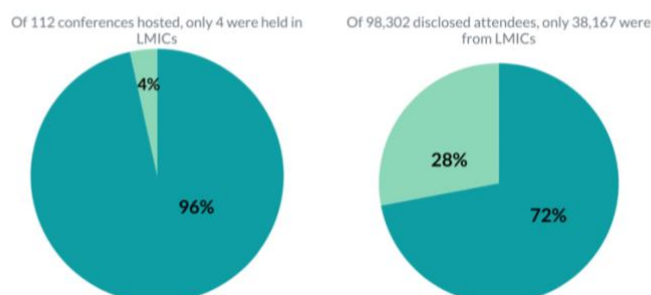
Source: BMJ Global Health, 2021

This demonstrates the need to reflect on the involvement and empowerment of local implementing partners and the importance of accessibility when it comes to organising conferences.

Our survey analysis revealed a similar pattern with regard to conference location (**Figure 6**).

Figure 6: Conference attendance limitations

Are members of your organisation provided with sufficient financial support when attending the conferences? Cost/visa friendly etc.

■ Yes (60%)　■ No (40%)

However, over 83% of the surveyed organisations confirmed that they were frequently invited to global health conferences with an equal mixture of both donor and implementing organisations. That said, despite the invitations, 40% of the organisations could not attend the conferences due to a lack of financial support alongside visa restrictions. Both of these barriers are linked to the fact that most of the conferences take place in North America and Europe.

A major consequence of not empowering local researchers and restricting their access is the lack of applicable, context-driven research. This extends to the frameworks used by global health projects that take place in LMICs. Academics and policymakers have advocated for the consideration of the local

cultural and linguistic contexts when using standardised assessment measures to gauge the success of global health projects.[24]

Crucially, imposing healthcare paradigms without consideration for the local context or what is referred to as the "idioms of distress" can lead to ineffective interventions.

The issue of knowledge production was also evident in the interviews with the global health experts. The experts echoed the need to generate localised knowledge in the context of LMICs. The research and strategies used by the organisations operating in the global health sector were at times not culturally sensitive to the needs of the individuals. For instance, one participant from the policy dialogue argued that research for gathering data is influenced by training and education, often from Western academia. For example, working on a paper on Cousin Marriage and promoting the narrative that cousin marriage is a problem, without considering the contextual reasons for the marriages at all. "A lot of us are unwilling to question what we've been taught by the Western society".

When further probed, experts also highlighted the need to evaluate the way knowledge is produced as this had an impact on the type of projects that were prioritised by the global health organisations. This was corroborated by the survey as after the completion of projects, only 15% of the global health organisations used evaluation guidelines created domestically/locally, and the majority used evaluation guidelines set by the donors (**Figure 7**).

Figure 7: Direction on monitoring and evaluation
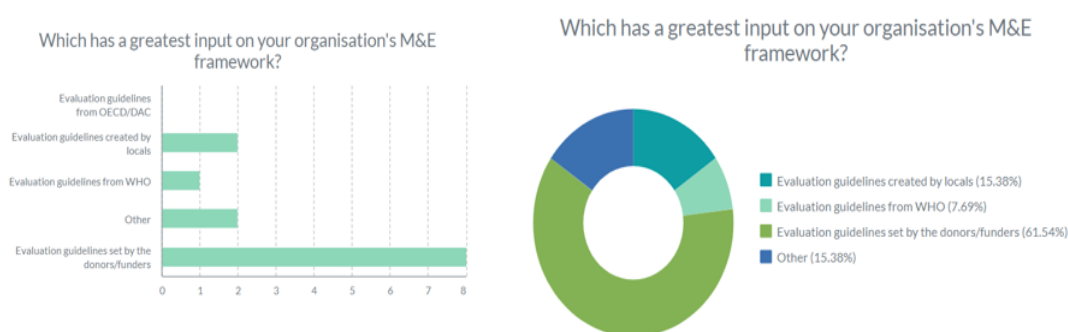
Along with this, the role of researchers in LMICs was also apparent in these discussions. The experts had emphasised the issues around "Western-focused research leadership" and the lack of accountability when projects were hijacked by western researchers. The experts expressed the reluctance of the global health sector to go beyond using knowledge produced in HICs and the lack of urgency to go from evidence to implementation upon discovering these key issues. However, one participant organisation in the policy dialogues noted their attempts to shift the focus to locally led investigations and research. They noted that their research team now puts focus on local researchers by seeking capacity building for university students while making sure the local researchers are frequently lead authors. "We are also keen on idea generation with them and make sure local researchers have the opportunity to present their work".

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[24] Carrie, H., Mackey, T. K., & Laird, S. N. (2015). Integrating traditional indigenous medicine and western biomedicine into health systems: a review of Nicaraguan health policies and miskitu health services. *International journal for equity in health*, *14*, 129. https://doi.org/10.1186/s12939-015-0260-1

Inspirational Case Study 1: Ebola burial practices in West Africa.

Problem: A lack of context driven policy – The tradition of washing/handling the body of the deceased is a prominent culture and religious practice in the West African region, but this also encourages human-to-human transmission of the Ebola disease.[25] Simple, non-contextualised guidelines would suggest enforcing stopping such traditions while the disease is being tackled, but research around pushback from locals as well as incidences of increased infections following burials[26] gave cause for a careful review of these rigid recommendations.

"In Guinea, we lost months because we didn't understand the culture. We didn't even understand that, in some areas, Muslims wash the bodies before burials. Safe burial techniques should have been one of the first interventions that we recommended. But because we — Western institutions and leaders — thought that we knew best, we had a lot of challenges with interrupting transmission of Ebola."- Ngozi Erondu, an associate fellow at Chatham House's Centre on Global Health Security.[27]

Solution: Organisations issued specific, new guidelines on how the bodies of the Ebola victims were to be buried in line with the scientific knowledge but with cultural allowances made for the bereaved families to perform their rites, albeit adjusted for risk. The guidelines were developed by an interdisciplinary team at WHO, in partnership with the International Federation of Red Cross and Red Crescent Societies (IFRC) and faith-based organizations including World Council of Churches, Islamic Relief, Caritas Internationalis and World Vision.[28] This "localising" adjustment improved local safety uptake and reduce further infections.[29]

Reflection: Focusing on context-driven research and authorship of local researchers and policymakers (e.g. in health guidance) is a great step to decolonize global health, and can lead to better results in practice, as the Ebola case illustrates. However, it is not enough as this does not challenge the knowledge itself. Global Health needs to re-examine its education and the knowledge that is being passed to students from both the Global North and Global South.

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[25] Manguvo, A., & Mafuvadze, B. (2015). The impact of traditional and religious practices on the spread of Ebola in West Africa: time for a strategic shift. *The Pan African medical journal*, *22 Suppl 1*(Suppl 1), 9. https://doi.org/10.11694/pamj.supp.2015.22.1.6190

[26] Lee-Kwan, S. H., DeLuca, N., Bunnell, R., Clayton, H. B., Turay, A. S., & Mansaray, Y. (2017). Facilitators and Barriers to Community Acceptance of Safe, Dignified Medical Burials in the Context of an Ebola Epidemic, Sierra Leone, 2014. *Journal of health communication*, *22*(sup1), 24–30. https://doi.org/10.1080/10810730.2016.1209601

[27] DEVEX . Q&A: 'Global health funding is far from being decolonized'. (2021) https://www.devex.com/news/q-a-global-health-funding-is-far-from-being-decolonized-says-ngozi-erondu-99667

[28] Relief Web (2014) Background on how guideline on safe burial were developed. https://reliefweb.int/report/world/field-situation-how-conduct-safe-and-dignified-burial-patient-who-has-died-suspected-or

29World Health Organisation. (2017, October). *How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola or Marburg virus disease.* https://www.who.int/publications/i/item/WHO-EVD-Guidance-Burials-14.2

Theme Two: The WHERE - Global Health Financial Power

Issues around global health processes tend to frequently feature concerns about local ownership and involvement in decision-making around projects, priority setting, and funding constraints tied (in some case literally) [30] to donor interests. In development projects, these practices are seen as incompatible with country or local ownership.

In the survey results, there was strong evidence of a lack of local involvement at the decision-making level. Only 50% of the participating organisations had agreed that their project met the needs and involvement of the local community (**Figure 8**).

Figure 8: Are projects contextually sensitive and meeting local needs?
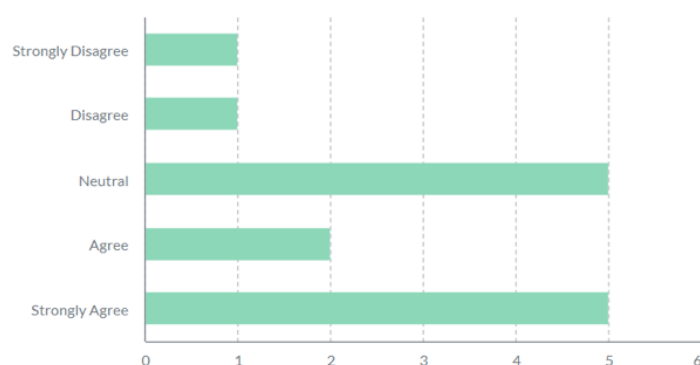
Additionally, limited access to the decision-making process is the most distinctive challenge in the process of global health, as all the organisations that answered this question responded that they have limitations in how much of a say they have in the decision-making aspect of the projects. Furthermore, the priorities of global health initiatives were often decided by donors. A number of organisations noted that restricted grants also made it difficult for them to find a balance between the local priorities and donors' interests.

The precarious nature of funding for some global health organisations is also under examination; donations are often earmarked by external actors that also have their own aims. For instance, often, global health organisations continue to tie the priorities of the projects to the foreign or commercial policies of the country they are funded by, instead of the needs of those who need the health intervention.[32] To give an example, many health interventions favoured are vertical interventions that are disease or health issue-specific, such as AIDS or malaria eradication. **Figure 9** attempts to provide a simple visualisation of the key differences between vertical and horizontal interventions, for the same types of results and outcomes.

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[30] Tied aid" refers to the phenomenon where procurement of grants or loans are limited to companies or organisations in the donor country or in a small group of countries. Tied aid therefore often prevents recipient countries from receiving good value for money for services, goods, or works – see: https://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/untied-aid.htm.

Figure 9: Vertical vs Horizontal Interventions: How they differ
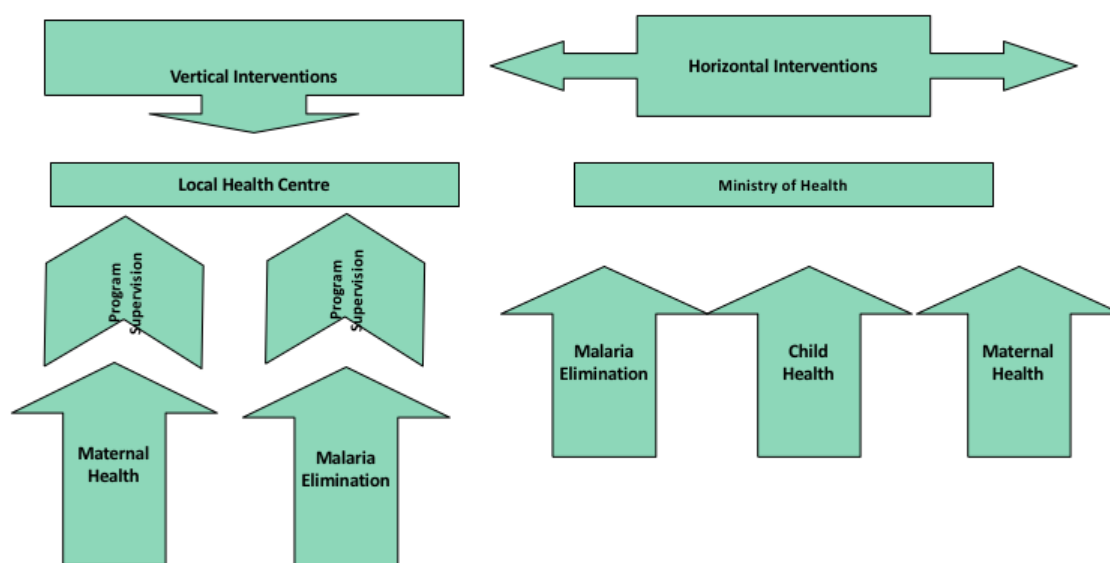
Source: Development Reimagined

Vertical interventions are favoured by donors – and have attracted huge funds - because of claims that the metrics of success are fairly easy to quantify - which improves the apparent efficacy of such projects, in comparison with horizontal interventions that encompass the broader health system and involve multiple issues being addressed simultaneously through primary healthcare.[31] They can also be negotiated with and implemented by familiar firms and organisations headquartered in the funding country (e.g. pharmaceutical firms), and therefore meet "national interest" criteria better when trying to persuade taxpayers to continue aid spending. Literature also suggests that the ineffective and expensive horizontal intervention-style 'Health for All by 2000' initiative by the WHO served to increase this vertical focus.[32]

However, vertical interventions can also divert critical resources from the health systems of LMICs, as these types of interventions are not entirely integrated into the health system. According to the World Health Organization (WHO), a possible implication of this is the 'brain drain' of healthcare workers from LMICs to global health institutions or countries in the Global North. This is due to vertical initiative funding systems leading to poor wages in the local health systems.[33] Such imbalances encourage health workers to disproportionately seek employment with better paying NGOs locally or emigrate entirely for better opportunities.[34] Vertical interventions thus may have been effective in tackling certain diseases in the short and medium-term, but their overall effect on the health of poor people has in recent years been questioned. The slow progress on tackling some of the key targets of the Millennium Development Goals (MDGs), and then the Sustainable Development Goals (SDGs) such as on maternal and child mortality, which rely on a strong overall healthcare system and primary healthcare has been partly blamed on this focus on vertical initiatives.[35]

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[31] Msuya, J. (2003). *Horizontal and vertical delivery of health services: what are the trade-offs (English).* Washington, D.C.: World Bank Group. http://documents.worldbank.org/curated/en/914491468761944686/Horizontal-and-vertical-delivery-of-health-services-what-are-the-trade-offs
[32] Ibid.
[33] Larsson, E. C., Atkins, S., Chopra, M., & Ekström, A. M. (2009). What about health system strengthening and the internal brain drain? Transactions of the Royal Society of Tropical Medicine and Hygiene, 103(5), 533–534. https://doi.org/10.1016/j.trstmh.2008.12.015
[34] Saravia, N. G., & Miranda, J. F. (2011, March 4). WHO | Plumbing the brain drain. World Health Organisation. https://www.who.int/bulletin/volumes/82/8/saravia0804abstract/en/
[35] Fehling, M., Nelson, B. D., & Venkatapuram, S. (2013). Limitations of the Millennium Development Goals: a literature review. Global public health, 8(10), 1109–1122. **https://doi.org/10.1080/17441692.2013.845676**
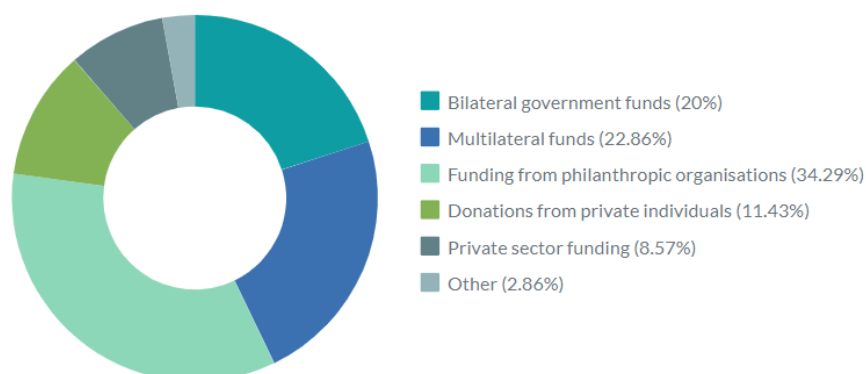
A survey response by an implementing partner organisation explained: *"In Mozambique… health financing was overwhelmingly dominated by donors with very vertical funds, which had an impact on our priorities when it came to selecting projects".* The organisation indicated that while both the government and donors had a major role in the decision making but there was a limited opportunity for important local actors to influence the direction of each project, due to earmarking. This was also echoed by similar grass-roots organisations; for which existing data shows that they receive less than 2% of direct funding,[36] despite being the best placed to effect lasting change.

The topic of funding and the priority setting in relation to global health projects was also apparent in the survey analysis and is supported by the current literature. The challenge of donor dependency presented as a major issue; around 55% of the global health organisations surveyed relied mostly on donor funding (**Figure 10**). As a specific example, the US government, which contributed 47% of all funding for neglected disease product development in 2016. In contrast, investments by LICs and MICs made up just 3% of R&D funding in the same year.[37]

Concerns over this donor-dependent funding system have been raised by a number of organisations during the dialogues. Firstly, funding agencies are mostly based in Global North countries which have not yet improved their donor/funding strategies. In this regard, implementing organisations often find it difficult to allocate sufficient staff time and other resources to carry out necessary activities due to restricted grants given by their donors.

Figure 10: Project fund sources: Where does the funding come from?

- Bilateral government funds (20%)
- Multilateral funds (22.86%)
- Funding from philanthropic organisations (34.29%)
- Donations from private individuals (11.43%)
- Private sector funding (8.57%)
- Other (2.86%)

The survey and dialogue responses indicated that more sustainable, agnostic, and non-donor driven funding mechanisms would help organisations choose better initiatives that fall in line with the needs of the community.

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[36] International Federation of Red Cross and Red Crescent Societies. (2015). *World disasters report 2015: Focus on local actors - the key to humanitarian effectiveness.* IFRC. http://ifrc-media.org/interactive/world-disasters-report-2015/

[37] Beyeler N, Fewer S, Yotebieng M, et al Improving resource mobilisation for global health R&D: a role for coordination platforms? BMJ Global Health 2019;4:e001209. https://gh.bmj.com/content/4/1/e001209

Figure 11: Global burden of disease compared to organisation priorities by SDG target[30]
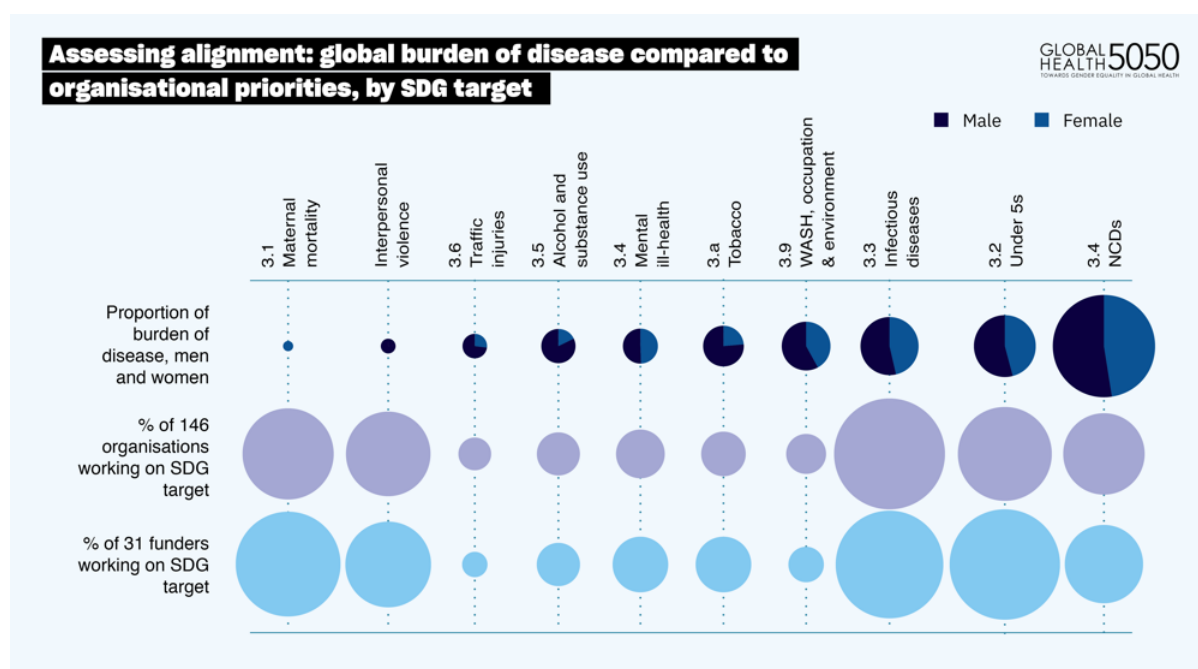
Source: Global Health 5050, 2020

When the health-related priorities of global health organisations were explored, there was a clear discrepancy between organisational aims and the burden of diseases in LMICs. **Figure 11** demonstrates how issues such as maternal and child mortality, which were on the agenda during the era of the Millennium Development Goals (MDGs; 2000-2015) are still high on the agenda despite its low proportion of burden in comparison to non-communicable diseases (NCDs), that currently cause the most premature deaths globally.[38] The mismatch in priority setting is also linked to the overarching theme of power imbalances in project ownership.

The survey analysis in **Figure 12** showed that there was an overall agreement on the existence of a power imbalance in the global health sector and that the global health sector needed to evaluate the way it had operated in low-income and lower-middle income countries. A large proportion (75%) of the organisations had strongly agreed that devolving power to the locals should be a key priority in global health and all of the organisations considered redistributing power in the global health sector as important or very important.

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[38] Global Health 5050. (2020). *Power, Privilege and Priorities*. Global Health 5050, London, UK. https://globalhealth5050.org/wp-content/uploads/2020/03/Power-Privilege-and-Priorities-2020-Global-Health-5050-Report.pdf

Figure 12: Does the global health sector need re-evaluation?

The Global Health sector needs to evaluate the way it operates in LMICs

There is an existence of a power imbalance in the Global Health sector

The needs of those from LMICs are mostly met by Global Health initiatives

Organisations that operate in the Global Health sector should have a sustainable plan for future projects

Devolving power to the locals should be a key priority in Global Health

When considering the governance and decision-making capacity on projects in developing countries, it was clear that many of the dialogue participants were aware of the power dynamic concerns. For many of these organisations, there was the realisation that the current model of decision making was unsustainable. They valued the local ownership of projects but also relayed the importance of complying with the objectives set by the donors. As a large majority of the global health organisations rely on voluntary contributions and donations, the precarious nature of their funding sources had limited the type of projects they were able to implement.

During the policy dialogue, one organisation noted that they had started to generate funding from more varied sources and delivery activities, for example charging consultancy fees and user fees. This helped them to boost resources and finance the activities they felt were most crucial for their communities. However, they also noted that they were empowered to do so by their main funder, and success is not always guaranteed. For many organisations it is a huge challenge to diversity funders, especially on short timescales and in contexts of poverty.

Finally, scholars[39] have highlighted the important of coordination platforms to incentivise funders, and researchers to share information about projects in the pipeline, past successes and failures and anticipated funding portfolios. This will minimise the likelihood of gaps and duplication in funding and support funders in making efficient investment decisions. Information-sharing mechanisms can include real-time updating processes to ensure transparency and ongoing alignment between global goals and global finance.

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[39] Ibid.

Inspirational Case Study 2: Actively untying health finance

Problem: Back in 2002, the Gates Foundation funded a "grand challenge" with the scientific community, one that would focus some of the brightest minds on improving global health. However, of the 44 leaders of the original Gates Grand Challenges Project, only one was from the developing world (China). The leaders of the grand challenge effort quickly realised this was a problem for sustainability. Ideas could not just be transferred out. They needed to come in.

Solution: Grand Challenges Canada was born from this realisation, with the motto that **"We invest where others do not.** Grand Challenges Canada 'actively untie' funding by inviting ideas and calls for proposals from a wide range of countries. The organisation funds innovators in low- and middle-income countries that integrate science and technology, social and business innovation to promote business innovation that's needed to make things work. So far, a pipeline of over 1,300 innovations in 106 countries have been funded by Grand Challenges.[40]

Reflection: Mechanisms to untie health are crucial, such as grand challenges, and can be very useful to introduce in global health organisations. However, they are not sufficient. They need to be designed to attract ideas, and those working on these mechanisms day-to-day need to value ideas coming from all over the world. They also need to be proactive – its' not just a case of wait and see what comes in.

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[40] Grand Challenges Canada. https://www.grandchallenges.ca/what-we-do/

Theme Three: The WHO - Governance in Global Health

In order to decolonise global health, it is vital that the key institutions involved in agenda-setting and decision making are at the forefront of addressing internal power imbalances. Issues relating to global health governance that cropped up frequently in the research, survey, and dialogues included the location of organisation headquarters in the global North, specific- development sector types of embedded salary pay gaps, and poor representation of LMIC persons and experts in leadership positions for global health. This is where the diversity and inclusion agenda comes in.

The majority of global health organisations are based in HICs and a recent survey of 198 global health organisations showed that nearly 90% were headquartered in North America or in Europe.[41] Part of the decolonising dialogue is to shift from the previous average of poor representation to increasing inclusivity and diversity within the structures that govern health projects in LMICs. Headquartering in HICs can automatically constrain the potential to do this – for example by requiring applicants for roles to be citizens of or have their own work permits in these countries[42]. This makes significant diversity hard to achieve, dependent on immigration policies that may themselves already embed racial profiling. Furthermore, many experts in the global health sector believe that without the input from partnering locals, global health initiatives will continue to perpetuate a Eurocentric worldview that does not adequately reflect alternative and often successful policy choices made elsewhere in the world as well as meeting local community needs.

Another key revelation relating to governance is internal recruitment practices around the use of dual salary systems. The use of dual salary systems has been flagged as a marker of pay inequality between researchers in LMICs and HICs, as evident from an assessment of pay inequality with 1,290 health workers across six LMICs and emerging economies, with the project's participants expressing general discontent with pay disparities.[43] Many organizations are beginning to explore how to close salary gaps between staff working at "headquarters" and in the "field", with an emphasis on blending the pay scales and improving equity.[44] Issues frequently noted in this regard included tax and currency conversion difficulties to balancing benefits for staff.

The challenges of a dual salary were also echoed in a wide-ranging "Open Letter to Senior Management and Colleagues in MSF: Beyond Words to Anti-Racist Action"[45] whereby over 200 staff from MSF highlighted the growing disparities between local staff and 'international/expat' staff - this included a persistent dual salary system across the organisation and unequal opportunities. MSF has now made a "one workforce" commitment across the entire organisation.

The survey analysis showed that half of the global health organisations in this survey did not operate in a dual salary system. However, 80% of the organisations who implemented projects directly were operating dual salary systems (**Figure 13**). The need to create sustainable salary systems that can accommodate both employees from HICs and LMICs was reaffirmed in the evidence review and during the dialogues. When discussing dual salary systems, one dialogue participant noted this is not entirely up to implementing organisations: "Pay scale variations seem to be driven in part by donors mandating different pay scales for 'international' and 'national' staff."

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[41] Pai, M. (2019, November 21). Lack of equity and diversity still plague global health research. The Conversation. https://theconversation.com/lack-of-equity-and-diversity-still-plague-global-health-research-127239

[42] Matahari Global Solutions and AIDS and Rights Alliance of Southern Africa (ARASA), Inception Report: Racial Diversity in Global Health (2021)

[43] Carr, S. C., McWha, I., Maclachlan, M., & Furnham, A. (2010). International-local remuneration differences across six countries: do they undermine poverty reduction work? International journal of psychology : Journal international de psychologie, 45(5), 321–340. https://doi.org/10.1080/00207594.2010.491990

[44] McWha-Hermann, I., Jandric, J., Wakefield, S., Carr, S.C., Grund, C., and Moutou, M. (2017). Project FAIR: Exploring practical pathways for reward fairness in international NGOs. Edinburgh, UK: University of Edinburgh. https://www.project-fair.business-school.ed.ac.uk/sites/project_fair/files/2020-09/project-fair-report-web.pdf

[45] *"Open Letter to Senior Management and Colleagues in MSF: Beyond Words to Anti-Racist Action.* https://docs.google.com/document/d/1FKb0jPiR5G0gNMNz-vuWPVwBnYjdoverHhysCDh_P88/edit

Figure 13. Salary structure differences

Does your organisation operate on a dual salary scale?

[Bar chart showing responses:]
- Yes: 4
- No: 8
- Sometimes: 2

(x-axis from 0 to 8)
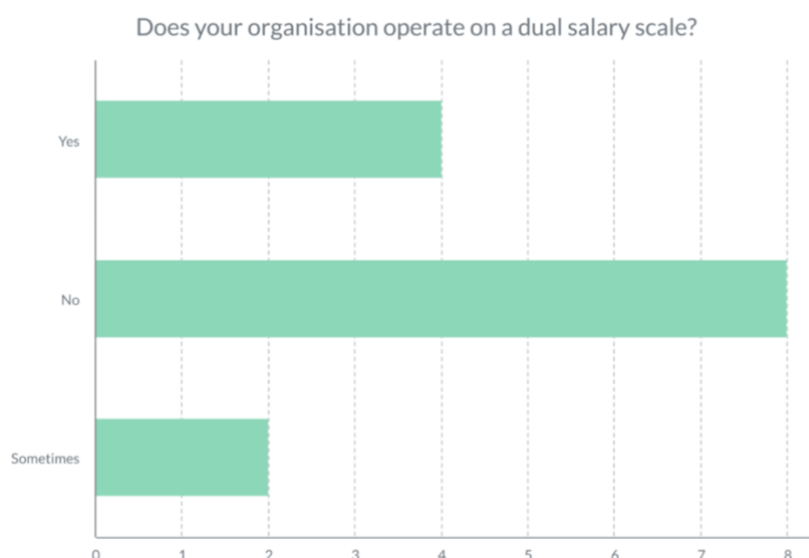
Another key challenge is related to staffing diversity, generally and at senior levels, as well as on advisory or other boards.[46] A few global health organisations provide specific reports on racial or geographical diversity. For instance, UNAIDS provides details of its geographical representation in its annual diversity reports, alongside gender and other categories. For 2019, while centralised reporting to UN Member States reveals that 26% of the close to 15,000 staff in UN's agencies – including UNICEF, UNDP, UNHCR and UNFPA - were from African countries [47], UNAIDS bespoke report shows that 29% of the organisation's staff were from a smaller subset of Sub-Saharan African countries, where the majority of HIV/AIDS cases remain.[48] Such accountability in the UN system and beyond is important, as has been recognised with regards to gender – for instance through the United Nations System-Wide Action Plan on Gender Equality and the Empowerment of Women 2018–2022 (SWAP), under which UNAIDS is also one of the best performing organisations.[49] Open Society Foundation has also recently begun to report on racial diversity in its two largest hub offices (US and UK), alongside gender (also reported for Germany).[50]

Some other global health organisations have made commitments, for instance, to diversify boards and senior management, to ensure better mentoring and the promotion of POC staff, as well as improve reporting mechanisms for racism.[51]

Finally, the ability to report on racist treatment or harassment without barriers is also a key part of decolonising the sector. Literature suggests racism reporting is difficult in the global health sector. For instance, it has been reported that in 2019, MSF received seven formal complaints of racial discrimination, of which less than five were confirmed following investigation.[52] The World Health Organisation in 2019 launched an internal investigation into, *inter alia,* allegations of racism against

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[46] Global Diversity Practice https://globaldiversitypractice.com/what-is-diversity-inclusion/
[47] UNDOC https://documents-dds-ny.un.org/doc/UNDOC/GEN/N20/304/60/PDF/N2030460.pdf?OpenElement
[48] UNAIDS https://www.unaids.org/sites/default/files/media_asset/UNAIDS_PCB46_A-Fit-for-Purpose-Workforce.pdf
[49] UNAIDS https://www.unaids.org/en/taxonomy/term/772
[50] Open Society Foundation https://www.opensocietyfoundations.org/employment/our-commitment-to-diversity
[51] For instance, see commitment statements by MSF UK, Mercy Corps, the Inter-Agency Standing Committee (IASC): https://msf.org.uk/msf-uk-board-trustees-statement-institutional-racism; https://www.mercycorps.org/press-room/releases/black-lives-matter;
https://interagencystandingcommittee.org/statement-principals-inter-agency-standing-committee-addressing-racism-and-racial-discrimination.
[52] The Guardian https://www.theguardian.com/global-development/2020/jul/10/medecins-sans-frontieres-institutionally-racist-medical-charity-colonialism-white-supremacy-msf

African staff members made initially in 2018.[53] This report has not yet been released. On the other hand, ensuring strong safeguarding against sexual exploitation and abuse and sexual harassment has been acknowledged as critical to the development sector's organisations proper functioning – such as the UK's FCDO, with monitoring and reporting mechanisms set up in this regard of UK aid recipients.[54] Such analogous systems do not appear to exist for global health (or development more broadly) with regards to racism, a key gap.

Inspirational Case Study 3: Changing structures to decolonise – WACI Health

Problem: Beginning in 1997, World AIDS Campaign International (WACI) was founded and headquartered in Europe, working in various geographical regions, including: Europe, Africa, Asia, Middle East and North Africa. It focused on raising public awareness on specific issues on the global AIDS response, supporting and strengthening campaigns on HIV accountability among diverse civil society constituencies worldwide. It led the planning and observance of the International World Aids Day, and in 2008 even registered its first office in Africa (South Africa). However, over the years, the organisation found it was increasingly difficult to be conscientious, innovative, accountable and streamlined in its approaches, due to its structure.

Solution: In 2016, the organisation decided to restructure and rebrand, to become a South African-headquartered organization – WACI Health. The organisation cut their headquarters staff numbers by two-thirds, yet still fulfilled their project responsibilities with the local team. WACI Health also has an African CEO, and diverse leadership team, and one of its donor organizations conducts staff pay equity reviews globally.

Reflection: Working to restructure global leadership and governance in global health to ensure more POCs at the top of the organisation as well as throughout the organisation is crucial, although not sufficient. It can, however, help ensure focus on the myriad of ways the organization internally and externally can incorporate decolonizing practices, including beyond staffing issues.

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[53] AP New https://apnews.com/article/health-ap-top-news-international-news-world-health-organization-race-and-ethnicity-0309500d252b4d63aab359d4c4e1965f
[54] FCDO https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/916516/Safeguarding-Strategy-10092020.pdf

## Theme Four: The WHAT – Global Health Procurement Practices

Having the ability to consistently procure drugs, devices, diagnostics, and equipment is a key part of both national and global health supply chains and is fundamental to the success of any health program. In this regard, issues around decolonising global health that were noted during the research, survey, and dialogues included practical challenges of obsolete supply chains, bureaucratic delays, and poor local supply of key goods and/or services, driven by the perceptions and systems that reinforce low levels and relatively more costly local manufacturing in poorer countries.

Specifically, although there has been significant investment in and progress made by many countries toward meeting the SDGs, there has been little improvement in access to essential medicines and medical supplies in developing countries, as procurement and supply chain structures, and especially those in the public sector, were often developed more than 50 years ago.[55] In addition, LICs and LMICs are gradually losing their eligibility for funding as the country becomes wealthier. For example, once the country GNI per capita exceeds $1,165, it is no longer eligible for IDA's concessional lending. Thus, many LMICs are subjected to procuring a large portion of their health products through centralised, donor-managed mechanisms, and often at subsidised prices or as donations, but can still pay as much as 20 to 30 times a minimum international reference price for basic generic medicines.[56]

During the interviews with global health stakeholders involved in the procurement process, it was evident that the procurement of health products remained heavily reliant on donors. According to the survey, approximately 30% of procurement funds were from philanthropic foundations. Bilateral donor and multilateral donor had accounted for a total of 40% (**Figure 14**).

Figure 14: Procurement funding sources
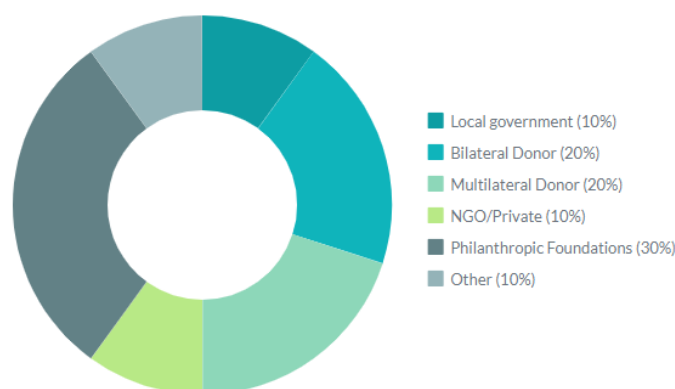
The practical challenges of procurement were discussed during the dialogue. Global health organisations have a pivotal role when it comes to the procurement of health products in LMICs. Organisations such as the UNFPA (United Nations Population Fund), UNICEF's Supply Division and Unitaid have a mandate on commodity procurement, market access, and delivery. Other global health stakeholders focus on the service delivery of the health products. An example is the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) which spends an estimated $2 billion per year

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[55] Magner, M., & Yadav, P. (2017). *Designing Global Health Supply Chains for the Future*. William Davidson Institute at the University of Michigan, USA. https://wdi.umich.edu/knowledge/designing-global-health-supply-chains-for-the-future/

[56] Silverman, R., Keller, J. M., Glassman, A., & Chalkidou, K. (2019). *Tackling the Triple Transition in Global Health Procurement*. Center for Global Development. https://www.cgdev.org/better-health-procurement

on the procurement of global health products, accounting for almost half of its overall annual disbursements in 2017.[57] In LMICs the purchasing power is often in the hands of a few global health donors. The choice is ultimately made by a small group of people, preventing robust scrutiny and cost, quantity, and capability comparisons.

There are also instances where the delivery of the health products can be delayed. One example the dialogue highlighted is that lack of local procurement options for almost any of the reagents has meant that they relied on international orders for complex super-cold chain items, despite needing small quantities. The reagents ordered took several months to get through various steps of the international regulation and ended up unfit for purpose.

Another challenge of centralised systems of procurement is poor local adaptation of procured goods. For instance, an organisation working in Peru, noted that it is one of just five countries in the world that has a specific electrical current. Due to the COVID-19 pandemic, oxygen was in short supply but like many other countries Peru has experienced huge shortages in access to medical oxygen and specific equipment. Oxygen concentrators can save a lot of lives, but due to a lack of perceived profit in the past, there were only four manufacturers in the world that were producing ventilators useable in Peru. The participant noted *"The solution was not easy. Incentives have to be presented… to drive otherwise low demand for certain goods and services."* Additionally, donor procurement requirements are seen as being very arduous, bureaucratic, and restrictive, putting limits to the accessibility of cost and availability of commodities in markets.

Associated with decolonisation, then, is the very real and impactful need for global health organisations to devolve more decision making around procurement to the organisations that were involved in the implementation.

However, analysis suggests that decolonisation can also involve a further step – ensuring sufficient incentives for local manufacturing. Despite facing some of the greatest burden of infectious diseases and poverty globally, the availability of essential medicines is the lowest in Africa.[58] Coming out of the HIV/AIDS crisis in South Africa in the early 1990s, there were considerable discussions on the importance of local manufacturing (including of generic medicines) in LMICs so as to reduce the dependency on external support and Intellectual Property (IP).[59] However, these challenges became somewhat obscured with the apparent success of vertical interventions (discussed under Theme 2). Yet, these can exacerbate these shortages, as they do not invest in the health systems or improve supply of essential goods and instead funnel needed funds into narrow projects.

The importance of local production was noted in a UNAIDS report published back in 2018, that aimed to encourage Chinese Investment into pharmaceutical production across the African Continent.[60] Key findings from the report showed that in 18 of the 21 African countries profiled, pharmaceutical production was considered a national priority, highlighting the demand for and commitment to local production amongst the surveyed countries. The report also showed that all the 21 countries already import Chinese health products, including limited TCM products, which occupy a maximum of 5% market share amongst the 21 countries. South Africa, Egypt and Nigeria are top importers of Chinese pharmaceutical products, with a 2017 value of over $300 million per country.

[57] Lindstrom, A., & Coronado-Garcia, L. (2020, May). Sustainable Health Procurement Guidance Note. United Nations Development Programme. https://www.undp.org/publications/guidelines-sustainable-procurement-healthcare-commodities-and-services

[58] Arney, L., & Yadav, P. (2014). *Improving Procurement Practices in Developing Country Health Programs*. William Davidson Institute at the University of Michigan, USA. https://wdi.umich.edu/wp-content/uploads/WDI-_-Improving-Procurement-Practice-in-Developing-Country-Health-Programs_Final-Report_2.pdf

[59] Russo, G., Banda, G. Re-Thinking Pharmaceutical Production in Africa; Insights from the Analysis of the Local Manufacturing Dynamics in Mozambique and Zimbabwe. *St Comp Int Dev* **50,** 258–281 (2015). https://doi.org/10.1007/s12116-015-9186-2

[60] Development Reimagined. New report aims to inspire more investment from China into Africa's pharmaceutical sector (2018) https://developmentreimagined.com/portfolio-posts/portfolio-04-3-2/

Improving procurement practices and innovating procurement systems in developing countries is becoming even more essential because these often-outdated systems face transitions in global health, such as transition from donor aid, global burden of disease is shifting from infectious to non-communicable conditions, the increasing number of health sector reforms to meet ambitious commitments to universal health coverage and cutting-edge technologies become commercial best practices. Improving procurement practices means focusing on the reform of lending policy from international agencies, the sustainability of the supply chain and ensuring country ownership of these supply chains. Focusing on how developing countries can produce and purchase goods and/or services through local suppliers can help achieve sustainability and build the capacity of local market actors and institutions and has been an area of focus for USAID and GAVI.[61] This is crucial in the long-term. Even if LMICs become wealthier and lose their donor funding status, they may struggle to make up for the loss in financing without local manufacturing systems.

In the survey analysis around half of the organisations relayed the importance of the local procurement of health products. In spite this, some organisations were not in support of the idea of local procurement, as they did not think that LMICs had the capacity nor existing infrastructure to do this. A lack of incentives to create a local manufacturing network has further led to an over- dependence on large private sector corporations based in the Global North. These discussions have now resumed pace in the light of COVID-19 vaccine access and calls for a "people's vaccine"[62]. The Africa CDC for instance in April 2021 launched a new, high-profile plan for local vaccine manufacturing in Africa[63]. A dialogue participant referred to this: *"There is a movement within the AU… to increase local manufacturing capacity both for the COVID-19 vaccines and for broader medical equipment, supplies and consumables as well…"*

During interview, a Chinese investor who operates two pharmaceutical factories in Mali and Ethiopia reflected that private investment to increase local manufacture capacity is a key means to not just increase the accessibility of lifesaving and everyday pharmaceutical supplies, but also practically deliver skills transferral and improvement in local management techniques.

As LMICs try to tackle the transition of losing donor status alongside a shift in epidemiological transition from the burden of disease and the focus on universal health coverage (UHC), the sustainable, decolonised procurement of health products is essential.

Inspirational Case Study 4: Local manufacturing of facemasks for COVID-19

Problem: In the Central African Republic, as the government stepped up its health response to the COVID-19 pandemic, the country was one of the first countries on the continent to mandate the use of facial masks. However, like many countries around the world, the government was faced with the huge challenge of procuring masks in local and international markets.[64] In countries where social distancing and confinement are difficult to impose, masks are an essential element of the response.

Solution: More than 2 million masks were produced in just two months and are being distributed for free to citizens in the Central African Republic through the World Bank LONDO project. Not only has the project saved lives it has generated over 400,000 individual workdays so far. [65]

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[61] Yadav, P., Alphs, S., D'Souza, C., Comstock, G., & Barton, I. (2018). Local Sourcing and Supplier Development in Global Health: Analysis of the Supply Chain Management System's Local Procurement in 4 Countries. Global health, science and practice, 6(3), 574–583. https://doi.org/10.9745/GHSP-D-18-00083

[62] Decolonising the vaccine https://mg.co.za/coronavirus-essentials/2020-07-06-decolonising-the-coronavirus-vaccine/

[63] Africa CDC https://africacdc.org/news-item/african-union-and-africa-cdc-launches-partnerships-for-african-vaccine-manufacturing-pavm-framework-to-achieve-it-and-signs-2-mous/

[64] World Bank Blog. Facemasks in CAR (2020) https://www.worldbank.org/en/news/feature/2020/08/03/a-lifesaver-in-times-of-covid-19-face-masks-made-in-post-conflict-central-african-republic

[65] Ibid

Reflection: The idea that poorer countries do not have sufficient "ability" to produce medical products can be seen as a hangover of colonial thinking. Experiences of scale up of local medical supplies through COVID19 serves as a call to global health organisations to shift these perceptions, and use their spending power on procurement to change the situation. For instance, global health organisations procuring supplies for use in LMICs could have a procurement policy with requirements set for at least 10% local manufacturing. This will go a long way towards driving incentives in this direction.

Theme Five: The HOW- COVID-19's Impact

In the previous sections we have already made references to the impact the COVID-19 pandemic has had on the other thematic global health challenges. This is because COVID-19 has served to highlight the already persisting inequalities in the global health sector, in both richer and poorer countries alike.

Back in 2020 when COVID-19 hit, there were headlines such as "African countries are at severe risk", and "Bill Gates warns the coronavirus could hit Africa worse than China." [66] This narrative wasn't surprising given that in 2019 the first Global Health Security (GHS) Index[67] (aiming to evaluate "the state of international capability for preventing, detecting, and rapidly responding to epidemic and pandemic threats") jointly published by Johns Hopkins University's Bloomberg School of Public Policy, the Nuclear Threat Initiative, and the Economist Intelligence Unit, ranked Equatorial Guinea as worst prepared out of 195 countries (16.5 points out of a possible 100), while the United States (83.5), UK (77.9), and the Netherlands (75.6) were best prepared. The best ranked African country was South Africa, at 34th, followed by Kenya at 55th. China was ranked 51st. [68] Fast- forward to 2021, and the story couldn't be any more different. This means a key aspect of decolonising global health is avoiding the assumption that global health organisations should only implement their programmes in poorer countries. Doing this would be in line with the commitment to and concept of "universality" embodied in the 2015 Sustainable Development Goals.[69]

Furthermore, the inequities of the sector have been spotlighted by the limitations imposed by the lockdowns and social distancing measures without adequate consideration of limited local resources which led to considerable economic strain in LMICs and for poorer and more marginalised communities in richer countries.[70] There have been logistics interruptions for goods and services – such as facemask and personal protective equipment (PPE) shortages at the early stages of the pandemic[71] and more recently for oxygen in India and beyond.[72] Global health governance vested interests are being revealed as contributing to lingering inequities in vaccine distribution currently.[73]

Overall, COVID-19 has made evident the weak points of a still "colonised" global health system; displaying the often-ignored fracture lines that hinder the penetration of development across the world. Improving global health in the wake of the COVID-19 pandemic may well require decolonisation - extensive review of local health systems, international health system integration, research in global health, and health goods production, among other areas.[74]

At the same time, COVID-19 has also provided a window into what a more "decolonised" global health system might look like. For instance, one notable insight from our interviews yielded that regarding research, COVID-19 has "pushed the locals" into doing data collection, as the travel restrictions meant that the "real scientists/researchers" could not go to do it themselves. Certainly, the disruptions have proven problematic; but they also present a unique opportunity to promote agency on the part of local / LIC institutions – both academic and civil society – to seek the resources and do the needed research themselves. Due to international travel restrictions, one implementing organization in the survey were able to engage community health workers who know how to best serve the needs of local patients in the project much better during the pandemic. Their organizations were also engaged in building

[66] Bloomberg. Bill Gates Warn Africa Could Be Hit Worse Than China. (2020) https://www.businessinsider.co.za/coronavirus-africa-2020-2

[67] 2019 Global Security Index https://www.ghsindex.org

[68] African Business. Does COVID-10 offer a new way of looking at African Risk. (2020) https://african.business/2021/03/technology-information/does-covid-19-offer-a-new-way-of-looking-at-african-risk/

[69] https://www.un.org/ecosoc/sites/www.un.org.ecosoc/files/files/en/qcpr/undg-discussion-note-on-universality-and-2030-agenda.pdf

[70] Lenhardt, A. (2020, December 17). *Pushing people further into poverty: the impact of Covid-19 in lower- and middle- income countries*. ODI. https://odi.org/en/insights/pushing-people-further-into-poverty-the-impact-of-covid-19-in-lower-and-middle-income-countries/

[71] Park, C. Y., Kim, K., Roth, S., Beck, S., Kang, J. W., Tayag, M. C., & Grifin, M. (2020). Global Shortage of Personal Protective Equipment amid COVID-19: Supply Chains, Bottlenecks, and Policy Implications. Asian Development Bank Briefs. Published. https://doi.org/10.22617/brf200128-2

[72] BBC. A nightmare on repeat - India is running out of oxygen again (2021) https://www.bbc.com/news/uk-56841381

[73] Eaton, L. (2021). Covid-19: WHO warns against "vaccine nationalism" or face further virus mutations. BMJ, n292. https://doi.org/10.1136/bmj.n292

[74] Reid, M., Abdool-Karim, Q., Geng, E., & Goosby, E. (2021). How will COVID-19 transform global health post-pandemic? Defining research and investment opportunities and priorities. PLOS Medicine, 18(3), e1003564. https://doi.org/10.1371/journal.pmed.1003564

capacity of local health systems and public education as responses to the pandemic. This response has accelerated important change in these organisations and shown that localisation IS possible.

Similarly, when it came to implementation, in our survey, around 75% of the global health organisations had significantly changed the way their organisation delivered global health projects, with the role of local community involvement changing in the process (**Figure 15**). Consequently, there has been several logistical changes at the operation level, for example the regulations on social distancing and travel restrictions meant that local delivery teams were fully responsible for all implementation.

Figure 15: COVID-19 changes to project delivery

capacity of local health systems and public education as responses to the pandemic.
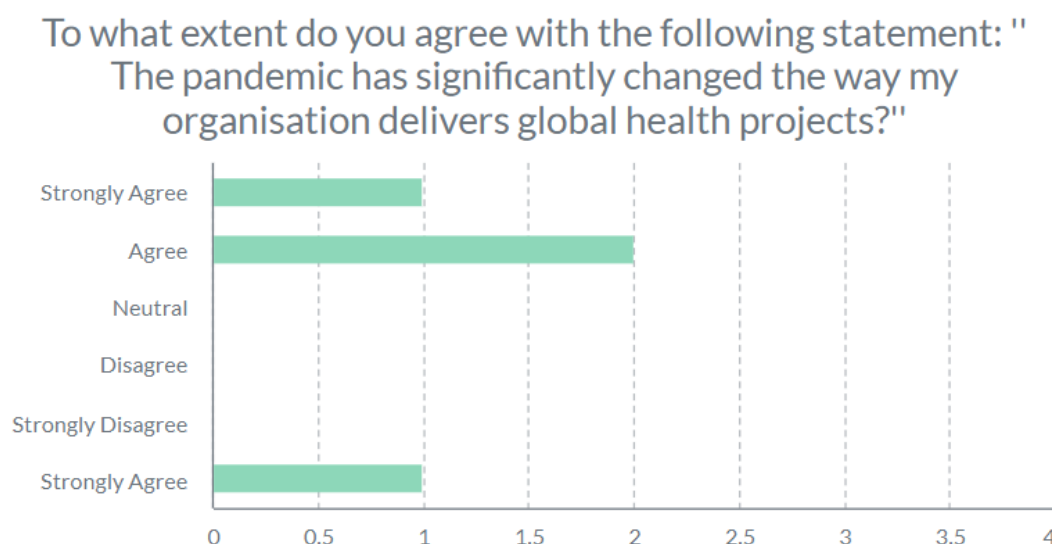
In the expert interviews, there was also the acknowledgment that the impact of COVID-19 on global health initiatives further stimulated the need to address the power imbalances and encourage sustainable practice that is centred around community empowerment. The pandemic has shown that countries with heavy focus on layered healthcare systems had a more resilient response to the pandemic. In contrast, countries with fragmented health care systems had to postpone vital vaccinations. For instance, in 2020, around 30 LMICs had to pause their measles vaccination campaigns to stop the spread of the coronavirus, leaving 94 million people at risk of missing these crucial vaccinations.[75] Experts highlighted the need to mobilise community members in order to reduce the dependency placed on external global health organisations.

Other opportunities brought by the pandemic were also highlighted in the survey. A growing number of virtual platforms for cross-site learning and sharing have been made available during COVID-19, which increase the accessibility of knowledge for many local staff. More organizations have become engaged in building capacity of local health systems and public education as responses to the pandemic. GIZ for instance, in April 2020, announced a partnership with a local company Kasapreko to produce hand sanitizer locally.[76] A month prior, Sansheng Pharmaceutical, based in Ethiopia, also launched a new production line to make hand sanitizers[77].

Noted options to consider for better global health post-COVID-19[78] include changing narrow funding pathways that prevent unified health systems; building UHC (universal health coverage) into global

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[75] Measles & Rubella Initiative. (2020, April 17). More than 117 million children at risk of missing out on measles vaccines, as COVID-19 surges. World Health Organization. https://www.who.int/immunization/diseases/measles/statement_missing_measles_vaccines_covid-19/en/
[76] News Ghana https://newsghana.com.gh/giz-kasapreko-to-boost-affordable-hand-sanitizer-production-in-ghana/
[77] Ethiosports https://www.ethiosports.com/2020/03/24/chinese-pharmaceutical-company-launches-hand-sanitizer-production-in-ethiopia/
[78] Lal, A., Erondu, N. A., Heymann, D. L., Gitahi, G., & Yates, R. (2021). Fragmented health systems in COVID-19: rectifying the misalignment between global health security and universal health coverage. The Lancet, 397(10268), 61–67. https://doi.org/10.1016/s0140-6736(20)32228-5

health services to ensure no person is left behind, improving gender inclusiveness and minority representation in decision-making and reviewing governance, policy and investment for global health.

Inspirational Case Study 5: Using COVID-19 to become universal

Problem: Partners In Health (PIH) has delivered health support in poor countries from its headquarters in the USA for many years. As COVID-19 affected the US as well as poorer countries, PIH saw restrictions interfere with normal operation, skilled staff availability and supply chains. Regulations on social distancing and travel restrictions made local care delivery teams fully responsible for all implementation, while also creating challenges for headquarter teams.

Solution: While implementation teams in poorer countries faced a higher burden of work, PIH also realised the solutions its local community health workers in poorer countries used could actually relevant to the US. PIH therefore launched the United States Public Health Accompaniment Unit (USPHAU) in May 2020 to assist states, cities and communities build a more equitable and comprehensive public health response to COVID-19.[79] This involved accelerating the creation of contact tracing programs, developing and trained stronger community health workforces, and working with jurisdictions and communities to establish equitable vaccine planning, communication and distribution. This community led approach supported a coordinated response and helped to shape lessons for others responding to the pandemic.

Reflection: COVID-19 presents an opportunity to increase local involvement and capacity building, and also to look more objectively at the health challenges across all countries, using lessons learnt and successful approaches from poorer countries in richer countries. This is key to breaking down the colonial perception that poor countries always need to be global health recipients. They can also be innovators.

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[79] Partners In Health launched the United States Public Health Accompaniment Unit (USPHAU) https://www.pih.org/us-public-health-accompaniment-unit

CHAPTER FOUR: CONCLUSION & RECOMMENDATIONS

The COVID-19 pandemic along with the Black Lives Matter movement has helped amplify the structural and institutional cases of racism, power imbalances and systemic weaknesses in all sectors and in particular the global health sector. This means the sector has a key opportunity now to deconstruct and refine the processes that go into global health.

This report has shown that a great deal of "decolonizing" change is already happening. Organisations are reflecting, becoming more transparent about these issues, recognising their internal areas that require rebalancing. The case studies provided in this report illustrate this vividly and provide significant inspiration in all five areas of the "decolonising" framework proposed.

However, the report also makes clear that progress has been quite limited, for five specific reasons.

- First, there is a risk that the decolonisation of global health discussion remains focused on pointing out problems and/or confined to the academic sphere. While both are crucial and the sector must deepen introspection and analysis, it is also crucial to initiate a focus on practical actions, on solutions that do dismantle colonial structures in the most influential global health organisations;

- Second, we have not found one global health organisation that is convincingly dismantling colonial structures in a holistic way. Some are putting more focus on diversity and inclusion, others on shifting the research agenda. And unfortunately, many are internally focused and not taken to scale to effect long-term, global change.[80] This means there are gaps. In particular, the local manufacturing agenda has not been linked clearly to the decolonisation agenda, which creates a risk that much investment and finance will flow into local initiatives in LMICs while procurement structures in the largest global health organisations including the UN remain imbalanced in favour of manufacturing in HICs.

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[80] Critical Thinking https://criticallegalthinking.com/2020/03/12/decolonisation-is-not-about-ticking-a-box/

- Third, while we are proud of the global health organisations that did join and input into the survey and policy dialogues, demonstrating their openness to being part of some sort of structure – a coalition of the willing – to decolonise global health, we are also aware that there were many highly influential organisations that did not, despite being invited to do so. In addition, during the policy dialogues there were some participants that expressed scepticism towards the decolonial agenda, and this scepticism is evident elsewhere too.[81]

- Fourth, there remains a significant risk that some of the engagement with "decolonisation of global health agenda" is – as one participant put it in an interview - "recolonisation". This risk may arise from – for instance, leading global health organisations seeking to shape the narrative to avoid the most uncomfortable and structural changes required, either because they are difficult, they do not understand why they matter in the long-term, or even more challenging, vested/conflicts of interest within global health systems. Being clear on *who* is leading the decolonisation debate is very key.

- Fifth, there also remains a risk that the changes prompted by COVID-19 are temporary – for example when frequent international travel resumes will consultants from HIC also resume travel back and forth? There is also the possibility of the more 'inclusive and open' Zoom conferences returning to in- person conferences in HIC.

That said, we hope this report makes a clear case that ultimately by "decolonising" using the framework we propose, global health organisations will ensure that they operate in line with the UN's SDGs, development effectiveness principles, and ultimately deliver more and better results for the people the organisations have their *raison d'etre* to support. Indeed, the diverse nature of the organisations which participated in the interviews and policy dialogue sessions provide the space for a set of key recommendations that will challenge unsustainable practices when it comes to implementing global health projects in the future. Implementing these recommendations may prove difficult, but they were ultimately put forward by the organisations themselves and suggests a proactive approach with an awareness of the thematic challenges can be transformational.

Recommendations

Based on these conclusions, our recommendations fall into two categories – 'substantive' and 'the process'. We begin substantively, based on the fact that each of the five themes provides specific potential targets and outcomes that can be monitored, evaluated and benchmarked during the process of decolonising. These are as follows.

1. **To address the WHY – in knowledge production**:

    a. **Prioritise local authors.** This includes making local authors the LEAD author/Principal Investigator and/or creating incentives/rewards within funding organisations to do so, allowing them the space to shape the topic/agenda, and providing the platform for the author to share this information both locally and globally to make sure access to this information is available for all.

    b. **Think carefully about the language used in knowledge production and rename institutions where relevant**. North vs South or Developed vs Developing, "tropical" medicine, etc - be open to changing language and structures used in style guides, analytical categories and even entire institutions that is derived from or feeds into colonial narratives.

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[81] For a Global South critique of the decolonization agenda see: https://www.opendemocracy.net/en/decolonisation-comfortable-buzzword-aid-sector/ and a discussion of anti-decoloniziation responses in medical education see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7880175/

    c.   **Adapt knowledge and guidance to local contexts.** Shape literature and analysis to ensure it is relevant to a wide range of political, economic and social settings – e.g. both formal and informal, urban and rural. Also, make knowledge products and research available in multiple non-European languages.

2.   **To address the WHERE – in financial power:**

    a.   **Untie funds and cut earmarking.** Allow non-national, local entities to have full ownership and delivery of e.g. at least 50% or more of funds. This will provide the space for funds to be locally targeted and to 'fill the gaps' that is often overlooked by donors.

    b.   **Delegate financial decision-making processes**. Target a percentage of funds (e.g. at least 20%) to be used in a flexible manner. Local institutions understand the urgent needs but also the longer-term goals. Create mechanisms to the space for organisations to generate extra resources.

    c.   **Rethink operation of/shift away from vertical funds.** Although demonstrating short term impact through vertical funds can be important, for greater long-term impact Ministries of Health need the flexibility to direct funding.

    d.   **Create mechanisms to send funds directly to locally-led organisations.** Examples include open, regular calls for proposals. Reduce bureaucracy and only standardise response templates where necessary to enable creativity and complexity of specific localities.

3.   **To address the WHO – in governance:**

    a.   **Monitor diversity, inclusion and local representation.** Create and monitor racial or geographical diversity targets throughout the organisation, and specifically within the decision-making positions and paid/unpaid advisory boards. Beyond headquarters, ensure that 'international' staff do not take precedent over 'national' staff.

    b.   **Drive diversity, inclusion and local representation.** Create direct incentives within procurement strategies that encourage stakeholders and partner organisations to do the same.

    c.   **Shift headquarters/diversity headquarters.** Global health organisations can relocate to countries where they focus most, to enable local ownership.

    d.   **Eliminate dual salaries.** 'National' staff should be paid according to experience not location/nationality. For ideas to be shared, knowledge to be generated and projects to be implemented, staff must feel empowered and equal.

    e.   **Create and strengthen reporting on racism.** Systems to report sexual harassment and exploitation are a useful model to replicate for avoiding racist incidents/systemic racism.

    f.   **Diversify location of conferences** away from HICs, include racial/geographical diversity targets in targeting participation, and provide funds for visas/travel on an "on-request" basis.

4.   **To address the WHAT – in procurement:**

    a.   **Go local**. Explore local manufacturing. Improve partnerships for local manufacturing to curb procurement bureaucracy. Create local procurement targets (e.g. 10-20% initially

ramping up over time) for vertical funds/aid organisations to create incentives to use local producers.

b. **Proactively invest in expanding local research and development.** This includes removing/avoiding intellectual property barriers. This will retain local talent in country but to provide the power to those who are often most impacted by global health issues.

c. **Proactively invest in expanding local manufacturing capacity and technology sharing.** Self-sufficiency is key for agile and robust health systems but this can only happen if technology is there in country – e.g. to manufacture vaccines, etc.

5. **To address the HOW – and learn from COVID-19's impact:**

a. **Formally record and track what has changed in organisations due to COVID-19.** Explore what has worked (and what hasn't) and ask local staff, partners and stakeholders what should be maintained long-term, and respond to those asks.

b. **Cut travel budgets.** The days of flying in for field visits or conferences must be limited. COVID-19 has demonstrated that local or national staff/organisation can respond to a crisis and maintain ongoing projects without international staff on the ground. However, the authority and decision making must be flexible and support must be provided.

c. **Be truly universal.** Challenge the assumption that global health interventions are only necessary in poorer countries, and restructure organisations to be able to intervene and share lessons from all over the world, as per implied by the SDGs.

Whilst all of the above recommendations may not be relevant to every single global health organisation, and there may be others we have omitted, we recommend that each organisation should take a holistic approach, while tailoring specific targets to their own ways of working or doing. Furthermore, it will be important to coordinate, share and learn from each other during the process.

Process-wise we have two recommendations.

First, monitoring and accountability is essential.

The need for accountability and M&E is crucial to scale decolonisation efforts. Sector-specific indicators and a results-based management framework along the lines of the substantive recommendations we have outlined above[82], used and reviewed annually in global health organisations, will help to assess decolonisation awareness, changes to policies on an organisational and national scale, and also identify the organisations that are adhering to good global health practice.

Second, the formal formation of a coalition of organisations willing to do this is essential, with effective leadership of the coalition.

Structurally 'decolonisation' underpins the achievement of all global health objectives – to reach everyone, everywhere, regardless of their race, social or financial status, gender, sexuality or location.

This report shows that a coalition of the willing is possible, the organisations we have engaged for this report can continue to push the conversation and increase the numbers of those willing to decolonise; to keep the fire lit and promote the exchange of solutions, ideas and structured plans towards the

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[82] United Nations Development Group. (2011). Results-Based Management Handbook: Harmonizing RBM concepts and approaches for improved development results at country level. UNDP. https://unsdg.un.org/sites/default/files/UNDG-RBM-Handbook-2012.pdf

process. Going forward, it will be essential to promote the discourse and cite workable alternatives to the current system. However, leadership is needed.

We propose the **UN University -International Institute for Global Health (UNU-IIGH)** as a sound, impartial and legitimate candidate for leadership of such a coalition, also given its reach and existing preparation for the effort. The **Action to Decolonise Global Health** (ActDGH)[83] group should also play an important role in shaping this agenda, especially once formalised.

It will be necessary to incorporate both substantive and process-based aspects of work into the coalition's strategy. The coalition should meet regularly, perhaps every quarter, and seek to expand over time - including a broader set of global health organisations and donors – both those already committed to take action and sceptics or detractors. The coalition should also engage with development sector organisations committed to promote country ownership – for instance on the latter the Global Partnership for Development Cooperation (GPEDC) and OECD will be important to engage.

Decolonisation will not be easy or pleasant; it will likely be uncomfortable for both the groups in power and those striving to leave deleterious colonial shadows behind. However, when it is achieved, it will ease the birth of a newer, more equitable global health system.

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[83] An activist, action-oriented collective of global health academics, practitioners, and students who have come together to put forward ideas, arguments, and strategies to reconstruct the global health system. The group is pushing a system that has more a equitable concentration power, where extractive policies are replaced with greater autonomy of people and communities. https://decolonise.health/about

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ANNEX 1

Survey Questions

1. What region is your organisation headquartered in?
    - Africa
    - Asia
    - Europe
    - Gulf States
    - North America
    - Latin America / Caribbean
    - Pacific Islands
    - Other (Please specify)

2. Where are most of your projects implemented? (Select all that apply)
    - Africa
    - Asia
    - Europe
    - Gulf States
    - North America
    - Latin America / Caribbean
    - Pacific Islands
    - Other (Please specify)

3. What is your organisation's staff size?
    - 1-25
    - 25-50
    - 50-100
    - 100-150
    - 150-200
    - 250+

4. What percentage of senior leadership in your organisation is locally recruited?
    - <10%
    - 20%
    - 30%
    - 40%
    - >50%

5. What part of global health does your organisation specialise in?
    - Reproductive, Maternal, Child and Adolescent Health
    - Nutrition
    - Water, Sanitation and Hygiene (WASH)
    - Infectious Diseases
    - Mental Health
    - Non-communicable Diseases (NCDs)
    - Neglected Tropical Diseases (NTDs)
    - Vector-Borne Diseases

- HIV/AIDS
- Health Systems Strengthening
- COVID-19
- Universal Health Coverage (UHC)
- Other (Please specify)

6. What aspects within these specialisms does your organisation work under? (Select all that apply)
   - Research & Development (R&D)
   - Procurement of health products (e.g. medicines/equipment, manufacture of medicines)
   - Health system operation (e.g. running clinics/hospitals)
   - Implementation of community projects
   - Health Policy
   - Health Financing
   - Other (please specify)

7. Does your organisation operate a dual salary system for local experts?
   - Yes
   - No
   - Sometimes

8. Is your organisation responsible for implementing global health initiatives directly?
   - Yes, all the time
   - No, none of the time
   - Sometimes

9. Does your organisation have other methods of implementing global health initiatives?
   - Yes
   - No

10. What other methods does your organisation use to implement the global health initiatives?
    - Partnership with local organisations
    - Partnership with global organisations
    - Partnership with private entities
    - Other (please specify)

11. To what extent do you agree with the following statements: (a) The Global Health sector needs to evaluate the way it operates in LMICs; (b) There is the existence of a power imbalance in the Global Health sector; (c) The needs of those from LMICs are mostly met by Global Health initiatives; (d) Organisations that operate in the Global Health sector should have a sustainable plan for future projects; (e) Devolving power to the locals should be a key priority in Global Health.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

12. How important is redistributing power in the Global Health sector to your organisation?
   - Not important
   - Slightly important
   - Moderately important
   - Important
   - Very important

13. Has your organisation made any attempts to take part in the decolonisation discourse?
   - Yes; the organisation has a strategy in place
   - No; the organisation has no strategy in place
   - Possibly; there are plans towards making a strategy

14. If your organisation has a particular strategy towards decolonising Global Health, can you offer more information on this?

15. What are some of the challenges your organisation is facing as you attempt to decolonise the global health sector?

16. Where does funding for your operations and projects come from? (Select all that apply)
   - Full Local funding (donations, government support) only
   - Mostly local funding
   - An equal mixture of local and donor funding
   - Mostly donor funding
   - Full Donor funding only
   - Other

17. What type of funding does organisation receive? (Select all that apply)
   - Bilateral government funds
   - Multilateral funds
   - Funding from philanthropic organisations
   - Other
   - Donations from private individuals (not philanthropic funds)
   - Private sector funding

18. How are priorities set when deciding on projects to fund?

19. Is funding for your projects earmarked by donors (Do have a say in the decision-making aspect of the projects your organisation takes part in?)
   - No - we have full ownership of projects
   - Some limits - we have some limitations but have a say in the decision making process
   - Mostly limited - we have a limited say in the decision making process
   - Fully limited - we have no say in the decision making process

20. How important is the local ownership of Global Health projects to your organisation?
   - Not important
   - Slightly important
   - Moderately important
   - Important
   - Very important

21.   Do you feel that your work as an organisation is acknowledged after the completion of projects?
- Yes
- No

22.   Can you expand on the type of acknowledgment you receive?

23.   To what extent do you agree with the following statement: "My organisation's approach to global health initiatives are contextually sensitive?" A contextually sensitive project considers the needs and involvement of the local community.
- Strongly Disagree
- Disagree
- Strongly Agree
- Agree
- Neutral

24.   Does your organisation have a Monitoring and Evaluation (M&E) framework to assess projects?
- Yes
- No

25.   Does your organisation conduct its own M&E framework or is it completed by external personnel?
- All of the M&E is completed by external personnel
- All of the M&E is completed by the organisation
- Some of the M&E is completed by the organisation
- Some of the M&E is completed by external personnel

26.   What aspect of the intervention does your M&E evaluate?
- Performance
- Evidence of effectiveness
- Impact
- Other

27.   Is your organisation familiar with the DAC Principles for Evaluation of Development Assistance?
- Yes
- No

28.   Which of these has the greatest input on your organisation's M&E framework?
- Evaluation guidelines from OECD/DAC
- Evaluation guidelines created by locals
- Evaluation guidelines from WHO
- Other
- Evaluation guidelines set by the donors/funders

29.   When publishing reports with partner organisations, how often are you credited with lead authorship?
- Always
- Most times
- Sometimes
- Rarely
- Never

30. Global health conferences are an important part of global health research, does your organisation receive invites to any?
    - Yes
    - No
    - Sometimes

31. How often is your organisation invited to global health conferences?
    - Always
    - Most times
    - Sometimes
    - Rarely
    - Never

32. Are members of your organisation provided with sufficient financial support when attending the conferences? Cost/visa waivers. Etc.
    - Yes
    - No

33. How important is the local procurement of health products to your organisation?
    - Not Important
    - Slightly Important
    - Moderately Important
    - Important
    - Very Important

34. Has your organisation been involved in the procurement of health products in LMICs/developing countries?
    - Yes
    - No

35. What was the role of your organisation in procurement?

36. If your organisation engages in procurement in LMICs/developing countries, what type of commodity does it procure? (Select all that apply)
    - Medicines
    - Diagnostic devices
    - Vector control tools
    - Other

37. Where does the majority of funds used to procure goods come from? (Select all that apply)
    - Local government
    - Bilateral Donor
    - Multilateral Donor
    - NGO/Private
    - Other
    - Philanthropic Foundations

38. Does your organisation face any challenges relating to the procurement of global health commodities?
    - Yes
    - No

39. What are the main challenges related to the procurement of these goods?

40. Does your organisation think that current procurement practices pose any challenges to developing local manufacturing in Africa?
    - Yes
    - No

41. Can you explain what some of these challenges may entail?

42. As developing countries become wealthier, donor financing for health products may become reduced, does your organisation have any long-term plans to address this?
    - Yes
    - No

43. To what extent do you agree with the following statement: " The COVID-19 pandemic has significantly changed the way my organisation delivers global health projects?"
    - Strongly Agree
    - Agree
    - Neutral
    - Disagree
    - Strongly Disagree

44. What changes have happened to the way your organisation operates as a result of COVID-19?

45. Has the role of local community involvement changed in line with the changes brought by COVID-19?
    - Yes
    - No
    - To some extent

46. Can you offer more detail on the manner and extent of these changes?