Shifting power in global health

Decolonising discourses — Dialogue 1

Convened by

UNITED NATIONS UNIVERSITY
UNU-IIGH
International Institute for Global Health

DEVELOPMENT REIMAGINED

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Wilton Park

SHIFTING POWER IN GLOBAL HEALTH

Decolonising Discourses — Dialogue 1

SUMMARY OF UNITED NATIONS UNIVERSITY, DEVELOPMENT REIMAGINED, AND WILTON PARK VIRTUAL DIALOGUE

TUESDAY 2 NOVEMBER 2021 (0800-1010 GMT & 1400–1600 GMT)

EXECUTIVE SUMMARY

The first virtual discussion in the series on “Shifting power in global health”, co-convened by the United Nations University International Institute for Global Health, Wilton Park, and Development Reimagined, took place at a time of increasing and continuing calls for a reassessment of global health and recognition of its colonial heritage.

This first dialogue, conducted twice to accommodate a range of timezones and ensure global engagement, began to articulate the ideas and visions of different groups for what a decolonised global health looks like. Here follows a synthesis of the two dialogues and a summary of the main points of discussion. This summary reflects the rapporteurs’ accounts of the proceedings and does not necessarily reflect the views of the rapporteur or partner institutions.

Key points from the dialogue:

- There is no single definition or movement to decolonise global health. Given the diversity and plurality of decolonising movements, due in part to different cultural, geographical and historical nuances, reasoned disagreement should be the aim. Reasoned disagreement will enable those working on decolonising global health to understand each other and develop core goals or principles for moving forward.
- 'Decolonising global health' is not a synonym for a range of other initiatives such as diversity, equity, and inclusion (DEI), or anti-racism efforts. Whilst many of the goals overlap, conflating agendas risks diluting the key focus on the enduring legacies of colonialism and the perpetuation of coloniality as specific structural determinants that contribute to continuing inequity.
- Understanding the distinction between 'decolonising' and 'decoloniality' is a key first step to decolonising global health. The latter's emphasis on the top-down matrices of knowledge, power, and control can be challenged.

- Whilst there are many routes to change, alignment on a set of underpinning values is required: vulnerability, voice, compassion, and inclusion. The issues of decolonisation and decoloniality will not be solved without interrogating these values.
- Global health sits within a broader global development architecture. Shifts in power are required to decolonise global health, and those with power, money and resources may have to give something up.
- Key voices are missing from the decolonising global health discussion. Increasing the diversity of views is essential, but how much will it influence decision-making? Other critical questions are: Whose lens is used to identify the missing voices? Are meaningful pathways to accountability created in the process? Who is accountable to whom?
- Dialogue participants provided suggestions to advance from dialogue to action, identifying three imperatives: i) the imperative to call out structural violence and institutional damage; ii) the imperative to mainstream a spectrum of epistemologies; and iii) the imperative to collapse centre-periphery divisions and dynamics.
- In identifying aspects of global health in which meaningful change could be achieved, capitalising on the current COVID-19 vaccine equity campaigns, creating mechanisms to include missing voices, facilitating South-South collaborations on decolonising global health, and adopting a holistic framework to deconstruct decolonising global health were all proposed.

A wide range of issues and topics were raised in this first discussion with notable areas of disagreement - a reflection of the complexity and nuance of the subject matter at hand. Subsequent dialogues in the series will provide an opportunity to deep-dive into a specific area and unpack the elements of divergence and disagreement. Each will seek to further expand the range of voices that are heard and to interrogate, and hopefully catalyse, what is needed for tangible progress. The next dialogue in the 'Shifting power in global health' series will focus on South-South collaboration to heed the imperative of dislodging the global North from its default setting as the centre of all conversations and collaborations.

INTRODUCTION

Over the past three years, individual and institutional voices have increasingly called for a reassessment of global health and greater recognition of its colonial heritage. From its inception as tropical or colonial medicine, via international health, through to its contemporary form, global health has been a field of research and practice that has privileged the voices of those in positions of power over the populations affected. Abimbola et al. (1) have outlined additional facets of supremacy, including patriarchy, racism, white supremacy, and saviourism that permeate global health. Together with colonialism, these facets have laid the foundation for a structurally flawed system—from research to governance to funding and procurement—that contributes to maintaining power asymmetries and privilege within global health.

Spurred in part by post-COVID-19 ambitions to "build back better", "decolonising global health" has gained pace as a collection of activist movements that seeks to transition from the theoretical to the practical. (2) Notably, many of the most vocal groups, whilst differing in approach, are led by researchers; however, a global cross-sectoral set of actors is needed to effect change. Furthermore, whilst it seems as though decolonising global health is a current hot topic, many highly influential organisations are not engaged in this topic, whilst others have actively expressed scepticism towards the decolonial agenda. (3, 4)

> IT IS AN IDEA WHOSE TIME HAS COME.

"Shifting power in global health" is a series of dialogues convened by the United Nations University, Development Reimagined, and Wilton Park. The series will bring together diverse stakeholders—especially underrepresented voices—for an open and honest discussion about the future of the decolonising agenda in global health. Each dialogue in the series will be hosted twice on the same day to maximise participation from different time zones. Under Wilton Park protocols, participants are invited to speak as individuals rather than representatives of their organisations. A safe space for an interactive and frank discussion is created through the assurance of non-attribution in the reporting of these sessions. (5)

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1 Abimbola S, Asthana S, Montenegro C, Guinto RR, Jumbam DT, Louskieter L, et al. Addressing power asymmetries in global health: Imperatives in the wake of the COVID-19 pandemic. PLOS Medicine. 2021 Apr 22;18(4):e1003604. DOI: 10.1371/journal.pmed.1003604

2 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. The report proposes a holistic framework for global health organisations to take steps towards decolonisation.

3 Horton R. Offline: The myth of 'decolonising global health'. The Lancet. 2021 Nov;398(10312):1673. DOI: 10.1016/S0140-6736(21)02428-4

4 Khan T. Decolonisation is a comfortable buzzword for the aid sector. Open Democracy 2021.

5 Wilton Park, *Event format and guidelines.*

The first dialogue began to articulate the ideas and visions of different groups for what a decolonised global health looks like and identify points of convergence. Conducted twice, participants were asked to indicate on an interactive map where they were from and where they are currently located as a reflection on positionality and inclusivity (Figures 1 and 2).

Each session comprised three plenaries followed by a discussion and one breakout group discussion (three groups) with feedback. The dialogue provided fourteen plenary presentations, feedback from six groups, and plenary discussion. Participants were also able to provide comments via the meeting chat function. This report brings together both sessions, presenting the key themes that emerged from participants' contributions, thoughts, and opinions.

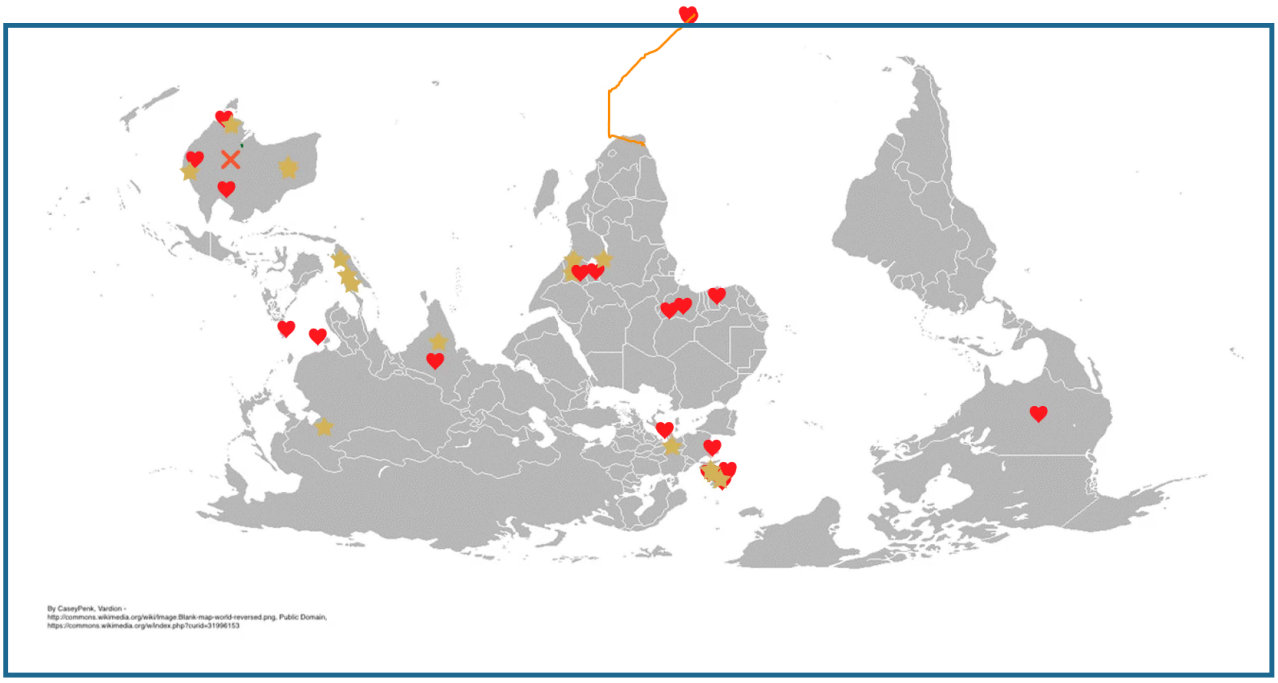

Figure 1: Reflexive map exercise from session 1 of the dialogue.

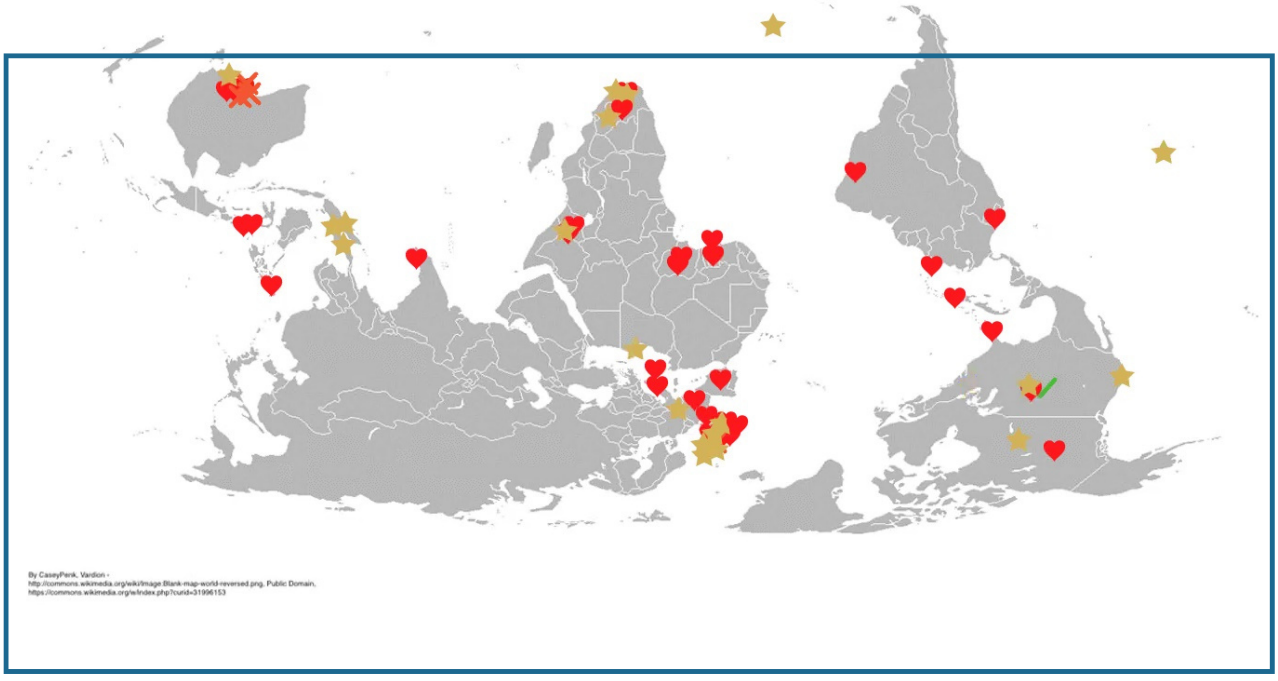

Figure 2: Reflexive map exercise from session 2 of the dialogue.

KEY THEMES

1. A common language?

There is neither a single definition nor a single way forward to decolonise global health, starting from a lack of consensus on what key terms mean and how they are best used.

- In the first instance, it is important to distinguish decolonisation from coloniality. (6, 7) Decolonisation is a process by which former colonies supposedly gain independence from a colonial power and often refers to the physical exit of the colonising population. Coloniality can be conceived of as a mindset or a set of multiple matrices of knowledge and power. (8) It is a useful shorthand for temporal, spatial and control matrices. The temporal aspects include a trajectory towards colonial definitions of 'progress' and 'development'. The spatial aspects relate to the global North and the global South, developed and developing, centre and periphery, etc. Control refers to the matrix of power that privileges control over bodies, microorganisms, processes, and so on.
- The term “global health” is also contested (9) and may not necessarily be useful in the decolonising dialogue. For instance, in some parts of the global North, global health simply means having a project in a low- or middle-income country (LMIC), whilst for others, it is an endeavour centred on equity. It is clear that “global health” means different things to different people, potentially complicating an already nebulous discussion.

> Decolonising global health can be viewed as a collection of movements rather than a single movement where different people are doing different things framed differently, where there are different temperaments and different focuses, with different cultural, geographical, and historical influences. What do we do with this much diversity?

In addition to definitional disagreement, different cultural, geographical, and historical nuances need to be considered. Reasoned disagreement as a manifestation of diversity and plurality in the decolonising movements will enable those working on decolonising global health to understand each other and develop core goals or principles for moving forward.

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6 Munshi S, Louskieter L, and Radebe K. The coloniality of being: Reflections on trauma, othering and reimagining praxis. International Health Policies 2021.

7 Ortega Y, Valencia A. Rethinking decolonization. Belonging, Identity, Language, Diversity Research Group (BILD) 2021.

8 Quijano A. Coloniality of Power, Eurocentrism, and Latin America, 49: Quijano termed this “the colonial matrix of power”.

9 Salm M, Ali M, Minihane M, and Conrad P. Defining global health: findings from a systematic review and thematic analysis of the literature. BMJ Global Health 2021;6:e005292. DOI: 10.1136/bmjgh-2021-005292

- Decolonising global health is a collection of highly contextual movements. As such, diversity of action is inevitable. There is the temptation to strive for consensus, but this would be counterproductive as one size will not fit all. “We need to allow for the diversity and plurality of movements and find ways to work together and find a common language”. (10) The nuances of cultural differences and roles within the strategies to decolonise global health will need to be considered. At the same time, it is essential to capitalise on current voices and connect those conversations in a Pan-African sense and South-South conversations more generally.
- The Asian decolonisation movement seems less developed, with advocates still grappling with the ideas of decolonising global health in this regional context. While there have been attempts to replicate the African experience in Asia, the region is very complicated when it comes to decolonising and decoloniality as Asia is a collection of former colonies, former colonisers, and aspiring neo-colonisers resulting in very different cultural, geographical, and historical nuances. The conversation is different again when considering the settler colonies that remain in Australia and New Zealand. Expecting decolonisation is unrealistic, further emphasising the importance of a decolonial approach.
- “To understand the present, we must understand the past.” Many believe that the fragmentation of the initial African decolonisation movement resulted in a continent that was liberated but not united, leaving it vulnerable to continued colonial influence. Historically, there were two main ‘camps’, one advocating absolute African unity to guard against neocolonialism and the other, newly independent countries wanting to consolidate their gains. Therefore, it is critical for Africans who are underrepresented in global health and are serious about shifting global health to learn from the missed opportunity to unify and speak with many voices but one language.
- History shows that understanding, not consensus, is the key to collaboration. The main actors in the African decolonisation movement may not have agreed conceptually, but one thing they did agree on was to put an end to colonial rule. Significant social changes, for example, the end of World War II, are never made up of people who agree conceptually, but at least they can identify goals. As such, reasoned disagreement founded on an understanding of each other will allow for the development of shared goals.
- While reasoned disagreement is the goal, consensus and unity are required on one front: the use of the term “decolonisation”, regardless of how uncomfortable it makes people feel: “Conceptual differences aside, decolonisation reminds everyone that global health is essentially a rebranded version of colonial medicine. Not a lot has changed as global health decision-making power still lies with the same people, and the power balance or imbalance remains the same. It is the same actors who control the resources, set the agenda, and make the decisions.”

10 Where pronouns such as “we”, “us” and “they” appear in the summary of contributions, they reflect the comments of the contributors and are not referring to the convenors of the dialogue.

- Decolonisation is a deeply personal set of issues for those who have experienced tokenism, box-ticking exercises, been told not to take it so seriously, and to "separate work from life". One participant explained that a series of very uncomfortable conversations are taking place in their LMIC-based institution: "What started as tokenistic exercises has become a process of mourning that has allowed space for the expression of hurt over the legacy that we are all a part of. The healing process has allowed us to create a kind of allyship and a fellowship."

Understanding the issues around decoloniality and the epistemology of knowledge sources is a first step to understanding decolonising global health. These influence thinking about principles of fairness, equity, rights, and justice. By separating out coloniality from decolonisation, the top-down matrices of knowledge, power, and control can be challenged. It could also be worthwhile to think through de-imperialising the decolonisation discourse.

- What is meant by decolonisation? Where are actors situating themselves on the spectrum in this discussion? The conversation around decolonising cannot proceed without due consideration of reparations, but would aid or global health ever think of reparations as what the system aims to achieve? And if this is not a tangible objective of decolonising global health, then what is?

> "Taking decolonial thinking seriously means stepping back and actually considering power structures. "Some researchers and institutions may need to walk away."

- Perhaps what would help with the first step would be understanding issues around decoloniality and understanding the epistemology of knowledge sources, of experiences that are considered valid. It influences thinking about principles of fairness, equity, justice, privacy, and rights. Even how these phrases are understood is caught up in a Western hegemonic understanding of what they mean. "Rights" means one thing in a northern capitalist order and another in other parts of the world. Knowledge production must be interrogated to avoid the perpetuation of coloniality through knowledge within global health.
- The constitution of knowledge bases is strongly influenced by colonial epistemologies. Ideas of "value", "expertise", and "right" or "wrong" knowledge need to be reconsidered. Even ostensibly objective and "scientific" processes such as the approval of medicine can be biased against knowledge systems that do not conform to Eurocentric norms; for instance, traditional medicines find it hard to make their way into mainstream health systems. There needs to be a challenge to these top-down matrices of knowledge, power, and control. The system of coloniality is proving fundamentally unsuited to the realities of our world, and its disconnects are being revealed materially and politically.

- It is essential not to conflate a range of other initiatives—health equity, health equality, diversity and inclusion, anti-racism, and social justice with decolonisation. These are not synonyms for decolonisation. (11) While these initiatives are important and can widen access, the system is not changed; power does not change. So, the questions become: what are the intentions of these discussions, how can the discourse be influenced, and where do participants want to situate themselves?

2. A new dynamic?

Decolonising global health needs to consider that global health sits within a broader global development architecture, which cannot be ignored. Global cooperation is required to decolonise global health, and those with power, money, and resources may have to give something up.

- It is difficult to accept the generalised definition of global health as a fundamentally benevolent system led astray. Furthermore, global health is nested within larger power imbalances that permeate global development and the global economy. The global capitalist system has been described as a system that is "an economic model of slavery." (12) If, at its core, it is a good system filled with good guys, why does it continue to exploit those it is meant to serve?
- There is the need to move away from the philanthro-capitalist model as significant parts of it do not seek to serve people but seek to serve masters. At the same time, people will defend a system that serves them, inequitably and inadequately, but serves them nonetheless, because what is the alternative if global health systems were to disappear overnight?

Purposeful underdevelopment, which commenced in colonial times and continues today through complex funding flows, has resulted in power asymmetries. There needs to be reflection on how to struggle with forms of power in which we are both instruments and objects. The citizens of the global North need to re-examine their moral values as supporters and beneficiaries of a global order that systematises oppression and economic extraction.

- Some participants argued that the current understanding of development is a farce. The funds—aid, loans, remittances—flowing into the African continent in 2016 were less than the funds flowing out. It occurs through illicit financial flows—trade mis-invoicing, tax evasion and resource theft.

11 Tuck E, Yang KW. Decolonization is not a metaphor. Decolonization: Indigeneity, Education & Society 2012 1(1).
12 Graeber D. Turning Modes of Production Inside Out: Or, Why Capitalism is a Transformation of Slavery. Critique of Anthropology 2006 26:61 DOI:10.1177/0308275x06061484

- As such, there is no such thing as development; there is only purposeful underdevelopment. It started back in colonial times and continues today through university training that programs people to continue this underdevelopment through poverty action labs, institutes for health metrics, social science platforms, development agencies, non-government organisations, and philanthropy. Very little is being done in this realm for reparative justice, leaving in place a failed development paradigm rooted in a neo-colonial extractive regime.
- Academics need to look at how to struggle with the forms of power in which they are both instruments and objects. This also means looking at moral relations not through a saviour model or helper model that leads to the development paradigm but as supporters and beneficiaries from a global institutionalised order that systematises oppression and economic extraction. It is not only aid agencies that collude in this continued extraction, but also global public health science. None of the goals of decolonising can happen without reparations and redistributive justice. (13) The global South must set the decolonising agenda, not the global North. Still, those in the global North reporting on the apparatuses that continue epistemic violence and neo-colonial extraction are important allies.
- The role of funding and money in the decolonisation discourse cannot be ignored. Unsurprisingly, a significant number of questions and comments were concerned with the power of funding organisations and their influence over funding flows. For example, UK development funding is declining and becoming more specific. Is the decrease in funding likely to be a good thing or not? How do funders either do less or improve their engagement in development? How does the politicisation of development play into this? Money is important, and the decline in funding is of concern, but it isn't the only requirement for global cooperation. Also required is the ceding of sovereignty by everyone. Understanding decolonisation helps show how the power wielded through or with money is a serious problem and leads to outcomes where donor funds are spent in donor countries, procured by donor country firms, and result in outcomes such as poor global vaccine distribution.
- There is a need to get powerful global health organisations such as WHO, "the claimed normative leader of the global health world", and the Gates Foundation, global health's largest philanthropic funder, to the decolonising and decoloniality table. If they took the lead, it would send a strong message to the global health community and may encourage others to come to the table. However, there were also concerns about at what stage in the process such actors should be engaged, given their outsized ability to dictate the narrative.

> "Why is it in these conversations, white experts speak as individuals while non-white attendees are only seen as "representatives" and not voices in their own right?"

13 Lancet Commission on Reparations and Redistributive Justice. See also: Richardson ET, Malik MM, Darity WA, Mullen AK, Morse ME, et al. Reparations for Black American descendants of persons enslaved in the U.S. and their potential impact on SARS-CoV-2 transmission. Social Science & Medicine 2021: 276: 113741. DOI: 10.1016/j.socscimed.2021.113741

Voices are missing from the decolonising global health discussion. Increasing the diversity of views is essential. However, consideration has to be given to how much increasing the diversity of views influences decision-making, whose lens is utilised to identify the missing voices, and whether meaningful pathways to accountability are created in the process.

- Who is already at the table, and what does that reveal about existing constructs of power and privilege? What and where are the current mechanisms to identify and bring in missing voices, including dissenting voices and those who fear repercussions for speaking up? While representation is crucial, to what extent does increasing the diversity of views tangibly influence decision-making and allocation of resources? Decolonising requires the creation of meaningful pathways for transforming decision-making and strengthening accountability – which voices and perspectives will help do so? What might be some of the trade-offs in including major power holders such as WHO, large donors, governments, and corporations?
- There is a need to consider power and agency in the conversation on representation and inclusivity – whose lens is being used to determine which voices are missing and worth including? While efforts were made to construct an inclusive participants' list for this dialogue, some voices ultimately declined to participate. What is revealed in the expectations that others should enter these spaces, and how does that intersect with a willingness to engage in spaces in which the balance of power has been shifted? The whole notion of inclusion itself can be a conservative gesture that fails to take on the structures that decide who is included and who is excluded.
- Could the lessons from apartheid and the truth and reconciliation process provide a safe space not just for dissenting voices to speak up but also for fearful voices to agitate? The African experience reveals a lag between agitation by the African diaspora and those on the African continent. It may reflect feelings of disempowerment, being scared about being vocal, losing a job or harming career prospects, or scaring off funders. For some, the response to an invitation to share lived experience is “Are you mad?”

Power without responsibility is problematic. A set of values to bring to the decolonisation conversation needs to be investigated: vulnerability, voice, compassion, and inclusion. The issues of decolonisation will not be solved without interrogating these values. The dialogue did not address how values play out in different countries, cultures and contexts.

- The accumulation of power is inevitable and not necessarily problematic. What is problematic is power without responsibility. More questions need to be asked about the why and how of global health and less about the what. A culture of responsibility needs to be created to replace the current culture of blame-shifting. Within the decolonisation discourse, actors need to identify a set of values that can serve as the foundation of conversation: vulnerability, voice, compassion, inclusion, authenticity, and integration. The issues of decoloniality will not be solved without first interrogating personal as well as shared values and teaching new generations about taking responsibility, being vulnerable, and letting go of greed and self-attachment.

3. From rhetoric to action

Concrete actions to move forward are required. The dialogue provided various ideas of sites, scale, and topics of action moving forward. Sites of action concern individuals, institutions, and structural change whilst suggested actions lie on a continuum from 'cosmetic change' to incrementalism to an exhortation by some to "burn down the current system". Topics of action included capitalising on current COVID-19 vaccine equity campaigns, creating mechanisms to include missing voices, and facilitating South-South collaborations on decolonising global health.

Three imperatives emerged from the dialogue:

i. The imperative to call out structural violence and institutional damage

- There is a need to deliberately move the conversation from the cosmetic to the challenging. "We need constructive discomfort. A re-examining of our positions and history without being defensive." Difficult yet necessary and constructive conversations need to thrive without fear of either recrimination or repercussion. (14) Allies need to take on the responsibility of educating themselves so that they can actively and productively participate in these movements, rather than relying on those in the global South to do everything from consciousness-raising to structural dismantling.
- The resources to good allyship exist – it is up to the individual to seek out the literature, to ask difficult questions, and to embrace the discomfort of challenging a system that benefits only a select few. Concessions are required in the name of restoring equilibrium, such as global North citizens choosing to work "in their own back yard" and turning down grants to work in the global South in favour of supporting work being done in the global South by the global South on grants they win and hold. The Global Health Decolonisation Movement in Africa, formed in early 2021, considers that a robust pan-African movement for the decolonisation of global health (15) requires coordinated advocacy, strategic communication, and patient capital. Strategic communication includes guidelines for high-income country researchers and institutions to reflect and shape their engagement with institutions in Africa.
- Knowledge production should be mapped to provide a better understanding of power relations in global health and where intellectual authority lies. Understanding power flows and networks will enable the identification of sites and avenues through which powerful actors can be held accountable. Investigative journalism could also have a role as journalists can activate conversations that academics may not be able to.

14 Watego C. Always bet on Black (power). Meanjin 2021.
15 Global Health Decolonisation Movement in Africa (GHDM-Africa).

ii. The imperative to mainstream a spectrum of epistemologies

- Labelling other epistemologies as "alternative" reinforces the default position of Eurocentric epistemology, despite good intentions. A horizontal spectrum of epistemologies which accords equal value to indigenous, non-western, and western knowledge needs to be created and institutionalized. The planetary health sector serves as an example of appreciating and incorporating other epistemologies and considers itself the decolonised version of global health.
- Knowledge is shaped by positionality. A plurality of epistemologies can only be achieved through a process of localisation, which would ensure country-based and country-led knowledge creation. Students, post-graduates, and staff can become change agents within their institutions: examining what goes on, reforming the way knowledge is taught and transmitted, changing hierarchies at multiple levels, co-creating research agendas, engaging in policy, and so on. Others on the African continent are doing likewise. (16)

iii. The imperative to collapse centre-periphery divisions and dynamics

- Decolonising global health requires a collapsing of the extractive colonial centre-periphery model which sees the global South as a source of raw data and the global North as the centre of knowledge production. Funders can play an active role in restructuring this system by increasing the flexibility of funding, reducing administrative burdens that serve as barriers to accessing funds, instituting country or continent quotas from particular areas to diversify funding allocation, and operationalising satisfaction surveys to continuously improve funding flexibility. (17)
- Donor and recipient countries can work together to end the cycle of dependency by identifying and defining the political obstacles to reforms, including their constituents, and providing solutions to dismantling said obstacles and implementing lasting structural change in the funding model from the global North to the global South. (18) As both contributors to and beneficiaries of public funds, the role of constituents must not be overlooked in this process. The global public plays a role in how notions of equity are operationalised and major players are held accountable, and active engagement with these constituents will lead to a better understanding of how these expectations and ideas are shaped.
- Vaccine nationalism and a large pattern of techno-nationalism serve as examples of the enduring centre-periphery division. Vaccines are donated, but technology is not transferred – this charitable model ensures a cycle of dependency which must be broken. Radical reforms to research and development are needed so that innovation leads to access; the discourse around COVID-19 vaccines serves as an ideal vehicle for advocating local manufacturing, intellectual property rights waivers, and equal and equitable partnerships that fairly centre and compensate the global South.

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16 See, for example, Carta Evidence Bibliometric Dashboard

17 The future of aid. The New Humanitarian 2020.

18 See *Open letter to international funders of science and development in Africa*: "Omitting African institutions from leadership roles and relegating them to recipients of 'capacity strengthening' ignores the agency these institutions have, their existing capacity, the value of their lived experience and their permanence and close proximity to policy-makers."

Concerns were voiced about performative action and cosmetic change. However, it was highlighted that such actions have a role to play in signalling movement and as potential drivers of normative change and thus should not be ignored. In this vein, the progress of global health over the past 20 years needs to be acknowledged if there is to be dialogue with the institutions which participants believe are in need of change. At the same time, there must be consistent and continued calling-out in order to move the decolonising agenda from the margins to the centre: "We need to define clear objectives around specific areas that can be achieved over time. The five-themed framework provided by Development Reimagined could assist in providing clear goals that are the key to observable change and progress over time. (2)

NEXT STEPS

Decolonisation in global health is not a topic for which there is a single solution. Indeed, seeking consensus would be problematic as the nuances of cultural differences and roles within the strategies to decolonise global health will need to be considered. For participants of this dialogue, the work to decolonise global health has only just begun, with a vast number of areas and topics in need of change to varying degrees and through varying mechanisms (Figures 3 and 4).

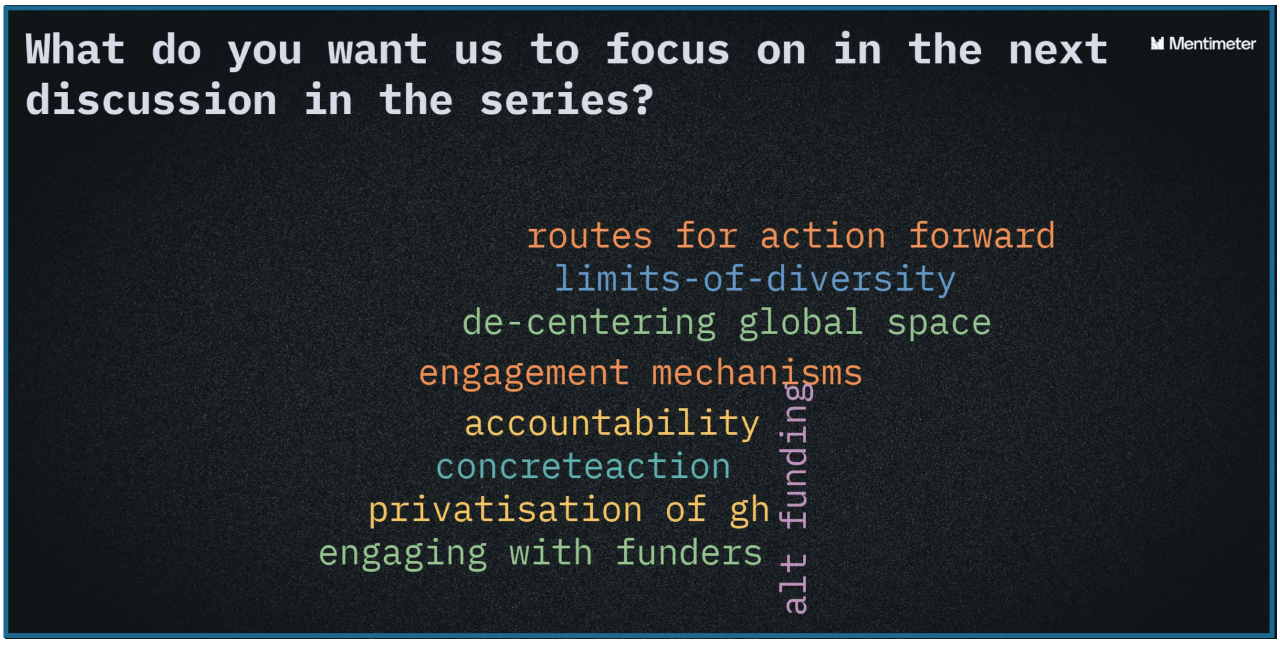

Figure 3: Suggestions from session 1 for areas and topics in need of decolonising.

2 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.

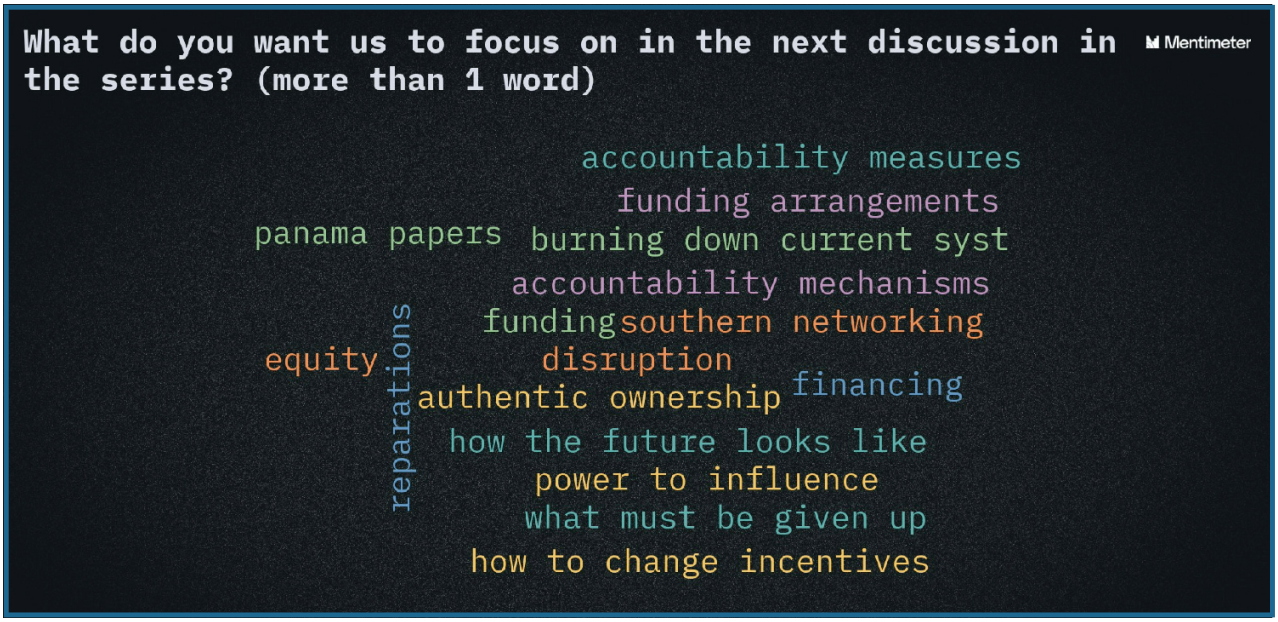

Figure 4: Suggestions from session 2 for areas and topics in need of decolonising.

As decolonising global health is discussed further in this series of dialogues, many questions remain: What is meant by the words? Where do participants want to situate themselves? What are these movements arguing for and is reparation a part of the process? How can this process be used to fundamentally influence decision-making? Are there ways to create pathways to the accountability of institutions? How to ensure that decolonisation and decoloniality are recognisable and not conflated with other health initiatives?

The next dialogue in the series will focus on South-South collaborations with the aim of bringing added clarity to these questions. Heeding the imperatives to mainstream a spectrum of epistemologies and collapse the centre-periphery model will expand the spaces in which these vital dialogues are taking place and broaden the sites of action to which participants look for best practices and potential solutions.

Colonialism and coloniality are still actively operating structures of power. It is essential to keep in mind that challenging colonial legacies and pushing for structural change is a process with no defined endpoint. This is not to suggest that attempts to shift power are an exercise in futility but rather that the decolonial journey will be constructed of many paths and will continue to evolve as new standards and ways of working are normalised and the expectations of what is possible grow.

ACKNOWLEDGEMENTS

The organisers of "Shifting power in global health: Dialogue 1" wish to thank all provocateurs and participants for their contributions to this series. Thank you as well to the joint organising team comprised of personnel from the United Nations University's International Institute for Global Health, Development Reimagined, and Wilton Park for supporting this and future dialogues in the series.

This report was prepared by rapporteur Helen Potts, with additional writing contributions by Emma Rhule and Tiffany Nassiri-Ansari.

To learn more about "Shifting power in global health" and participate in future dialogues, please contact:

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