The art of medicine

Is it possible to decolonise global health institutions?

In the past year, decolonising global health has gained prominence. Much of this movement has come from students of global health in high-income countries and preceded the recurrence of Black Lives Matter movements after the violent murder of George Floyd. Black Lives Matter and Decolonising Global Health movements have managed to shake schools of global health if not to their core then at least awake. As a reaction schools of global health have made statements about racial equality and have avowed to address racism, increase staff and student diversity, and to train their staff in the art of decolonisation. I have been involved in these processes of decolonisation at my own institution. Yet I also view such efforts critically.

What is it that institutions of global health are seeking to decolonise? What do they commit to when they speak of decolonising curricula and hiring fixed-term anti-racism consultants? Although it is crucial to change the internal structures of academic institutions to combat inequities and advance equality, diversity, and inclusion (EDI), if we want to transform institutions of global health it is equally important to recognise that internal institutional systems were historically designed to maintain overall structures of power. Institutional processes of decolonisation themselves will always be constrained by the imaginations and willingness of global health leadership in high-income countries to bring about and finance sustainable and fundamental change.

To do better and break the cycle of commitments to decolonisation and anti-racism without sustained long-term action to implement real change, it is instructive to consider how decolonisation emerged as a political movement and historical reality. The writings of Frantz Fanon are foundational. Fanon, a Martinican psychiatrist, philosopher, and fighter in the Algerian war of independence, wrote about anti-Black racism, decolonisation, and African independence and the psychological trauma they caused in both Black and white people before his early death in 1961. I keep coming back to this quote, published in a 1964 translation of Fanon's book *Toward the African Revolution*:

> "Many colonized peoples have demanded the end of colonialism, but rarely like the Algerian people. This refusal of progressive solutions, this contempt for the "stages" that break the revolutionary torrent and cause the people to unlearn the unshakable will to

take everything into their hands at once in order that everything may change, constitutes the fundamental characteristic of the struggle of the Algerian people."

To those immersed in institutional processes of decolonisation in global health, some of Fanon's phrasing is familiar. His description of "progressive solutions" and of "stages" will resonate with all those global health practitioners who have listened to leadership plans to implement change. There are differences between the historical contexts of revolutionary action in 1950s Africa and institutional processes in high-income countries in 2021. Yet both are supposedly committed to bringing about the same result: decolonisation. Western powers were reluctant to give up power in the 1950s—political pressure and violent insurgencies forced their hand. If institutional processes of decolonisation today are an attempt to complete the reversal of western political and economic dominance in politics, the economy, and health governance, we have to ask ourselves whether it is realistic to finish in working groups what began through insurgent action. Given the inherent violence of colonialism, Fanon saw the need for violence in overthrowing colonialism in all its forms to free people from White supremacy and internalised racism. I am not advocating violence, but I am questioning whether we will achieve structural change while seeking progressive reform and working through channels that were set up within structures that uphold White supremacy.

Global health's predecessors—colonial and tropical medicine—were designed to control colonised populations and make political and economic exploitation by European and North American powers easier. This exploitation was justified through discourses, policies, and structures that advocated for the biological difference and ensuing political superiority of White Europeans. That is the very definition of White supremacy. As the historian Randall Packard has shown, the transition from tropical medicine and colonial health to the current global health system was fairly seamless. Colonial administrators were replaced by technocratic experts: neither concerned with the socioeconomic realities on the ground and the messy afterlives of the targeted, yet often short-lived disease eradication programmes they favoured. Modern global health institutions were designed to work within a system of inequality whose colonial roots were largely overlooked. It has been more comfortable to explain global health inequalities largely through biomedicine and culture than colonialism. So although I am not advocating violence, I am advocating anger and revolution. The global health community should be angry because the polite institutional processes with which we are trying to decolonise belie the

structural violence and hurt caused by racism in global health institutions. Systems and institutions fail people, especially people of colour, all the time. And they are likely to continue to do so while EDI and decolonising processes work their way through global health institutions. In my view, increased speed is not the answer to making past wrongs right. Brutal honesty might steer us in the right direction.

I question whether decolonising global health institutions is possible. If we want to work towards health justice, the institutions that have been built on and benefitted from the racist exploitation of Black, Brown, and Indigenous populations the world over cannot decolonise and keep their epistemic, political, and financial power. If global health institutions are serious about their commitment to working against the legacies of colonialism and fighting racism, then they will need to give up some or all of their power. That means a radical redistribution of funding away from high-income countries, a loss of epistemic and political authority, and a limitation to our power to intervene in low-income and middle-income countries (LMICs). That is unlikely to happen. Systems and institutions protect people, especially White people, all the time.

If global health institutions are to engage in EDI and decolonising processes I would like them to do it more honestly than is happening now. An honest approach to fighting colonial legacies costs something. It costs time, energy, and money. A colleague of colour paraphrased the great Toni Morrison as saying racism is a massive waste of time. I would add that it is also a massive waste of money and emotional and physical energy. People of colour have known this for centuries and we won’t get that time or energy back, now that global health leadership is finally listening. And that hurts. For all of us to be able to start on a level playing field, processes of decolonisation need to cost global health institutions and their leaders something—financially and emotionally. No more unconscious bias trainings and surveys into the experience of staff and students of colour, tokenistic hiring of diverse staff, and inclusive leadership retreats without sacking people for racist, discriminatory, and oppressive behaviour or for turning a blind eye. Right now we’re trying to improve a broken system without removing the parts that are broken. Anti-racism and decolonisation do not simply mean being nicer to staff of colour and people from LMICs. It means cutting those people off who have benefitted from the system and used their privilege to discriminate against others or let an oppressive system go unchallenged. It also means recognising that some people in the global health community have tried to change the system from within for a very long time without recognition. There is a risk

that they are pushed aside now by flashy consultants and everyone's scramble to prove their decolonial credentials.

But there are other reasons why I think we need to do more than decolonise global health. If we have learnt one thing from historical processes of decolonisation it is that global missions should fill all of us with dread, even if they are designed to do good and improve local conditions. That is how colonialism was justified and how global health sees itself. Attempts to change this system should not take the same top-down, worldwide approach. What good is localisation, if those in leadership positions in global health institutions largely subscribe to systems that have advanced White supremacy. Moreover, many global health leaders have predominantly studied at the same universities—schools that are themselves products of a colonial and often racist system.

We—Black, Indigenous, and people of colour—do not want to be set free, we will fight for our own freedom and dignity. And, indeed, we are fighting now, participating in institutional processes, trying to steer them in a more radical direction. Similarly, patient communities across the world do not need global health leaders to determine access to which medicines should be prioritised or what disease eradication deserves priority. We owe it to them to create spaces and pathways, systems and structures that will dismantle the current system and make way for one in which it won't cost another Black man's life for global health leadership to listen. For a system in which one account of racism will be enough to inspire anti-racist action, and where our demands and experiences will not be met by ever-increasing demands for more proof and more data and more surveys. The problem is White supremacy. It has been White supremacy all along. What Fanon wrote in 1964 still holds true today: We need to take everything into our hands "in order that everything may change".

Lioba A Hirsch

London School of Hygiene & Tropical Medicine, London WC1E 7HT, UK

lioba.hirsch@lshtm.ac.uk