# The art of medicine

## Will global health survive its decolonisation?

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

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

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

To decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level. Supremacy is not restricted to White supremacy or male domination. It concerns what happens not only between people from HICs and LMICs but also what happens between groups and individuals within HICs and within LMICs. Supremacy is there, glaringly, in how global health organisations operate, who runs them, where they are located, who holds the purse strings, who sets the agenda, and whose views, histories, and knowledge are taken seriously. Supremacy is seen in persisting disregard for local and Indigenous knowledge, pretence of knowledge, refusal to learn from places and people too often deemed "inferior", and failure to see that there are many ways of being and doing. Supremacy is there in persisting colonial and imperialist (European and otherwise) attitudes, in stark and disguised racism, White supremacy, White saviourism, and displays of class, caste, religious, and ethnic superiority, in the acquiescing tolerance for extractive capitalism, patriarchy, and much more.

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

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

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Martin Luther King Jr (1929–68)

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

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

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

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

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

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

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

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

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