Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby gran to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____4/29/2021_____

Sedem Adiabu

Decolonizing global health from the perspectives of global health actors in Low-middle Income Countries

By

Sedem Adiabu

Master of Public Health
Department of Global Health
Rollins School of Public Health
Emory University

_____

Jim Lavery
Committee Chair

Decolonizing global health from the perspectives of global health actors in Low-middle Income Countries

By

Sedem Adiabu

B.S. Biology,
Fairleigh Dickinson University,
Teaneck, 2017

_____

Jim Lavery
Committee Chair

An abstract submitted to the Faculty of the
Hubert Department of Global Health
Rollins School of Public Health of Emory University
In partial fulfillment of the requirements for the degree of
Master of Public Health
2021

Abstract

Decolonizing Global Health from the perspectives of global health actors in Low-Middle Income Countries

Ongoing debate on decolonizing global health has elucidated stark power imbalances in partnerships among High Income Countries (HICs) and Low-Middle Income Countries (LMICs). Concerns about colonial legacies within the field may be hampering efforts to achieving health equity. While attention is growing on decolonizing global health, the perspectives of global health actors from LMICs have not been adequately explored. Their unique contextual knowledge surrounding the basis of this movement presents a critical opportunity to generate ideas on dismantling existing colonial forces blocking global health's mission. In this study, qualitative measures were employed to describe the perspectives of global health actors in LMICs on what decolonizing global health means to them. The target population were mid-level health professionals from LMICs, and the sampling frame was Emory's 2019 Humphrey Fellows. A critical qualitative analysis for participant interviews revealed three thematic areas -Political manipulation, Hypocrisy, and Distrust that describe key areas of attribution to global health challenges impeding global health equity. Additional data were collected on their recommendations in realizing a decolonized state of global health within their respective countries. Findings revealed how politics, hypocrisy, and distrust among HIC and LMIC partnerships correspond to uphold power imbalances. Recommendations on decolonizing global health fell into the following categories: a shift in perspectives, flexibility in donor requirements, meaningful dialogue, and intentional capacity building.

By
Sedem Adiabu

Acknowledgements

I would first like to express my sincerest gratitude to my mother for instilling the invaluable skill of discipline and perseverance in me. I am greatly indebted to the contributions of the 2019 Humphrey Fellows, without which this project would not have been possible. Thanks to my committee chair, Jim Lavery whose mentorship and guidance were the foundation to this thesis project. Tremendous thanks to Flavia Traven, the Hubert Department of Global Health faculty, and my classmates for their endless support and encouragements.

I would like to give thanks to my family and friends for putting up with my nocturnal habits during these last 2 years. Special thanks to Anjum Mandani, Lul Mohamud, and my Dad for offering their unwavering support and time.

I would also like to thank the Focus Area for Compassion and Ethics in Global Health (FACE) program at the Task Force for Global Health. Their unwavering allyship and training was transformational in this Master's program and reinforced my passion for work in global health ethics and social determinants of health.

In all, thanks to my faith and practice which is the driving force to fulfilling my mission as a committed health justice advocate and always remaining true to myself.

Table of Contents

Abstract

Ongoing debate on decolonizing global health has elucidated stark power imbalances in partnerships among High Income Countries (HICs) and Low-Middle Income Countries (LMICs). Concerns about colonial legacies within the field may be hampering efforts to achieving health equity. While attention is growing on decolonizing global health, the perspectives of global health actors from LMICs have not been adequately explored. Their unique contextual knowledge surrounding the basis of this movement presents a critical opportunity to generate ideas on dismantling existing colonial forces blocking global health's mission. In this study, qualitative measures were employed to describe the perspectives of global health actors in LMICs on what decolonizing global health means to them. The target population were mid-level health professionals from LMICs, and the sampling frame was Emory's 2019 Humphrey Fellows. A critical qualitative analysis for participant interviews revealed three thematic areas -Political manipulation, Hypocrisy, and Distrust that describe key areas of attribution to global health challenges impeding global health equity. Additional data were collected on their recommendations in realizing a decolonized state of global health within their respective countries. Findings revealed how politics, hypocrisy, and distrust among HIC and LMIC partnerships correspond to uphold power imbalances. Recommendations on decolonizing global health fell into the following categories: a shift in perspectives, flexibility in donor requirements, meaningful dialogue, and intentional capacity building.

Introduction

Over the last few years, there has been a growing interest in decolonizing global health. Global health is described as both a discipline, and practice that is concerned with improving health and achieving equity in health for all populations worldwide (Beaglehole R. & Bonita R., 2010). While this definition is widely recognized by global health practitioners, it is befitting to point out existing varied approaches to global health and the central paradigm guiding global health activities- global health ethics (Stapleton et al., 2014). Borrowed from medical ethics frameworks, global health ethics is conceptualized as a branch within global health that applies moral values to health issues at the global level. Both rely on context specific elements which may require modifications and present challenges to achieving equity in health, globally (Holden et al., 2016). The connection between decolonizing global health and global health ethics is concerned with reducing socially produced, and avoidable health inequalities informed by principles that support fairness and preserve human dignity. Global health ethics places human rights and moral values at the core of its function, thereby anchoring the rationale for decolonizing global health (Pinto & Upshur, 2007).

The movement to decolonize global health stems from a discussion about inherent power asymmetries among high-income country (HIC) and low-middle income country (LMIC) partnerships; and how these partnerships have colonial underpinnings that influence global health initiatives which often take place in LMICs. Moreover, significant health disparities continue to widen despite amassed efforts to eliminate them (Kirwan, 2009). The word

decolonize operates on the assumption that overturning institutions embedded in colonial legacies would need to occur for global health to function optimally or rather, equitably. If colonial ideologies shape how global health is researched and practiced, then it would be imperative to examine and begin dismantling structures perpetuating any identified disparities.

Contemporary literature attributes these colonial legacies to the root causes of global health challenges (Greene, 2016)(Kim, 2014)(Chandanabhumma & Narasimhan, n.d.) which may be hampering efforts to achieve health equity (Chandanabhumma & Narasimhan, n.d.). However, beyond unequal power dynamics, there is a lack of agreed understanding as to what decolonizing global health means to LMIC global health actors, to whom it benefits (Abimbola & Pai, 2020), and what it would entail within the global health community.

To date, 'decolonizing global health' discourse remains dominated by Eurocentric perspectives (*The Activists Trying to "decolonize" Global Health | Devex*, n.d.2019), which are rooted in western ideologies and frameworks. This is evident in the way universities and organizations situated in the global north conduct webinars (Roeder, A. 2019) and hold "decolonizing global health conferences" ("*Decolonizing Global Health: A Student Conference at the Harvard T.H. Chan Public Health School*", 2019) to discuss power dynamics and equity in research partnerships among European and American universities and researchers in South America, Sub-Saharan Africa, and Asian countries. Consequently, it would be counterproductive to only consider decolonizing global health through the lens of HIC global health practitioners. Doing so will not only present a biased reflection on the subject, but it will also be an

incomplete account of the lived experiences of those affected by colonial credos that persist in global health today.

I maintain that a more effective approach to understanding the decolonization of global health ought to prioritize the perspectives of global health actors from LMICs. Their unique proximity and relationship with colonial structures and practices presents an opportunity for critical engagement and a more accurate description of the challenges to achieving health equity. There is a paucity of studies exploring decolonization from the perspectives of global health actors from LMICs. Thus, a need for further examination of current global health ideologies by these relevant actors is merited. The purpose of this thesis is to describe the perspectives of global health actors in LMICs on what decolonizing global health means to them.

Background

To dialogue about decolonizing global health, one must first be primed on the premise of the movement. Global health stems from a dark unreconciled history, built from oppression and injustice (Assenova VA, 2017). Mapping the challenges of global health today therefore would require one to travel back in time to when journals were publishing articles on infectious disease in the global south under the guise of *International Health* (Lancet, 1969), mainly affecting colonizers, and exemplary scientists were contesting in vaccine development at the hands of experimentation on black and indigenous bodies in formerly colonized countries, also known as *Colonial Medicine* (Horton, 2013).

Colonial medicine established structures to protect the health and economic interests of colonizers (Greene, 2016). Extractive in its approach and goals, population control became a critical element in its transition from colonial medicine to international health (Global Health 50/50, 2020). International health took on a paternalistic manifesto which focused on specific diseases in the colonies aimed at preventing spread to the western world (Packard, 2018). Colonialism failed to consider indigenous people's opinions or input effectively eliminating them from any decision-making authority over their own lives. In addition, it instituted the socially-produced 80/20 wealth gap that would become the basis of health disparities across the world. Without changes to the systems that fortified colonial medicine, the term global health emerged with the intention of improving health and achieving health equity (Koplan et.al, 2009).

Colonialist education founded our collective understanding of human existence and development which are inextricably linked to how healthcare is designed (Affun-Adegbulu, 2020). The treatment of indigenous peoples as subjects rather than narrators in their own stories is a common thread stitched in colonial culture and such practices under the guise of aid can be traced to colonial projects that threatened indigenous health outcomes (Eichbaum, 2020). For instance, British officials of 1763 intentionally distributed blankets infected with smallpox among American Indians (*Vectors of Death : The Archaeology of Eu-*, n.d.) or the forced movement of East African people and livestock in the midst of sleeping sickness epidemics (Headrick, 2014) and more widely cited, the systematic "othering" and racial

classification of black and indigenous bodies with regards to pain management (Drwecki, 2015) As Chandanabhumma (2019) powerfully illustrates, “cultural wisdom of communities may be undermined by western definitions of health and well-being.” Equally, global health is practiced in a parachute-like fashion whereby, a technical expert enters a country, assesses the problem, disregards any existing solutions from the community and reports their findings to the global (western) community (Abimbola, 2019).

Mapping the Challenges

The current global health landscape is riddled with inequalities (Cash-Gibson L., 2018), misaligned priorities (Ren, G., 2020), discrimination (Williams et al., 2003), and systematic barriers to achieving global health equity (Buyum AM., 2020). Correspondingly, power and influence within global health is disproportionately skewed in leadership, knowledge production, accountability, and funding (*Report 2020 – Global Health 50/50*, n.d.). Health inequalities persist because individuals have unequal access to basic needs such as education, job security, health care, clean air, and water (Hanefeld, 2008). In that regard, colonialism functioned by collecting resources from elsewhere to develop certain societies while simultaneously under developing others (Klein & Rodney, 1974) . Global health, the entrusted discipline to remedy this imbalance, is largely unequitable internally (Global Health 50/50, 2020). Population level healthcare emphasizes the root causes or underlying factors that lead to disease or illness. On the contrary, global health discourse seems to be taught, discussed, and practiced in ahistorical and apolitical ways (Renzo, 2019). This incongruity between the

conceptualization and application of global health demands critical reflection on where the field is headed and how this current model is expected to achieve health equity.

The Current Movement

The decolonizing global health discourse was sparked after uproar from a job posting by the London School of Economics seeking an African health system expert but requiring that they be located in Europe (The Lancet Global Health, 2020). Simultaneously, student activists took to organizing conferences and discussions on the need to interrogate existing global health curriculums which fail to contextualize inequalities as a result of political and historical determinants (#DecolonizeGlobalHealth, twitter). Accordingly, a call to move away from global health "success stories" and catalogue its complex realities was expressed in conferences, online webinar events, and social media. Existing decolonizing discourse examines global health education, knowledge production, geopolitics, and governance (Eichbaum et al., 2020)(Abimbola, 2019)(Herrick, 2017)(Frenk & Moon, 2013). Recent works interrogate whether it is even possible to demolish a system that thrives on inequalities and whether global health will survive its decolonization (Hirsch, 2021)(Abimbola & Pai, 2020). Moreover, Covid-19 exposed cracks within the current model in global health agenda setting, vaccine allocation and supply chain, clinical trials, and racial discrimination (The Lancet Global Health, 2020) (Büyüm, Kenney, Koris, Mkumba, Raveendran, et al., 2020)

Decolonizing global health scholars propose a shift in global health research, policy, and practice (Tuck & Yang, 2012)(Abimbola, 2019) (Lavery et al., 2013)(Kevany, 2016) (Badejo et al., 2020). Global health education in universities and unfair international partnerships have also

been interrogated (*Decolonizing Global Health Education: Rethinking Institution... : Academic Medicine*, n.d.)(Lavery & Ijsselmuiden, 2018). Although these viewpoints are derived from the global north, however one noteworthy study investigated research processes among South Africans and offered important lessons about power, trust, and community recognition when conducting research within marginalized populations (Mpoe and Swartz, 2019). In 2009, a public-private partnership between National Heart, Lung, and Blood Institute (NHLBI) of the U.S. National Institutes of Health, and United Health Group (UHG) sponsored 11 LMIC-based research centers to tackle the growing NCD burden across LMICs (Engelgau MM et al, 2018). More recently, decolonizing global health conferences have partnered with LMIC institutions which may generate important revelations (University of Global Health Equity Kigali, Rwanda, *Journal of decolonizing disciplines*, 2020).

Existing bodies of literature on decolonizing global health question power dynamics that manifest through how global health is taught, researched, practiced, and marketed. Most thought pieces describe decolonizing discourse as a metaphor for repairing institutions that were built on colonial principles. While many chart the inadequacies that perpetuate injustice and unfairness within the enterprise, none of these thought pieces represent the perspectives of global health actors positioned in LMICs.

Significance

There is a deficit in knowledge about decolonizing global health from global health actors living in formerly colonized countries. Global health actors living in LMICs have unique contextual knowledge that should be privileged in decolonizing global health discourse. My

hope through this study is that their insights will help clarify what decolonizing global health would look like as well as guide our thinking as a global community (students, researchers, practitioners, donors) on what actions can be taken to both decolonize and improve global health. Generating this knowledge is critical in realizing health equity. The inherent value of these findings could be utilized to inform future global health programs involving fair international partnerships, specifically: capacity building, supply chain, and resource allocation. Since this study is exploratory in nature further research and a more robust sampling frame may be worth investigating to develop a greater understanding of LMIC health actors' experiences across different regions of the world.

Additionally, data from this study can be used to develop a questionnaire which will gauge LMIC global health practitioner's perceptions on decolonizing global health; a salient next step in holistically understanding the depth and scale of the issues and clues on where to begin dismantling structures impeding global health's aim to achieve health equity worldwide. Additionally, documenting LMIC perceptions on decolonizing global health discourse may provide a means to construct policies, make informed decisions, and provide a guide to direct equitable practices within the field. The purpose of this thesis is to describe the perspectives of global health actors in LMICs on what decolonizing global health means to them.

Methods

Study Design

To better understand what decolonizing global health is from the lens of global health actors in LMICs, a qualitative study design was employed utilizing grounded theory for data

collection and analysis. A flexible interview guide was constructed, focused on dissecting participants' understanding of global health as an enterprise; how they envisage a decolonized global health; their views on the challenges in their respective countries; their perspectives on international partnerships; their takes on who is responsible for decolonizing global health; their professional opinions on how to decolonize global health; and the implications of decolonizing global health for global health programs in LMICs. The interview process was interactive and conservational, allowing for participants to introduce other relevant matters.

Study population and Recruitment

The aim of the study was to solicit ideas on what decolonizing global health means for global health actors from low- and middle-income countries. A convenience sample of Emory's 2019-2020 Humphrey fellow cohort was utilized, and emails were sent for recruitment. Humphrey fellows represent a unique community of mid-career professionals from developing countries that come to the United States under a one-year professional attachment program focused on leadership development and collaboration with U.S. counterparts. Interviews were conducted with six (n=6) Emory University, Rollins school of Public Health's Humphrey fellows.

Data Collection

Data collection occurred through semi-structured one-on-one interviews performed on online video conferencing platforms. Interview schedules were prepared according to participants' availability and meeting preferences. Open space was established for deep reflection and probing as recommended by *Constructing Grounded Theory A Practical Guide through Qualitative Analysis* (Kendall et al., 2019). Interview duration varied from 45 minutes to

90 minutes and each encounter was recorded for transcription. All data collected was de-identified to ensure participant confidentiality.

Data Analysis

A combination of conventional and summative content analysis was employed to analyze the transcriptions. The interview process was iterative and analyzed successively using a thorough coding scheme to categorize concepts and sub-themes according to findings. Memo writing strategies as described by Lempert (2007), stimulated a reflexive process that informed future interviews. In accordance with the naturalist paradigm, data was analyzed using MAXQDA for coding and segmentation.

Ethics Statement

This research received Emory Institutional Review Board exemption for non-human subject's research (May 2020). Both verbal and email informed consent was obtained from all participants.

Results

The participants of this study involved perspectives from various developing countries including sub-Saharan Africa, Middle East, and North Africa (MENA), and Southwest Asia. Global health experience ranged from research to programmatic backgrounds and represented occupations were physician, program officer, and district medical officer. All participants had previous experience working with international organizations in their respective capacities. These interviews yielded rich discussions on the following themes and sub-parts which are described in detail below. The three themes that emerged from the data are unified by the concept of power. Participants described several experiences of power imbalances in their

interactions and participation in global health. Their experiences and commentaries guided the development of the thematic framework presented in figure 1. Post-colonial political trajectory, Hypocrisy and Distrust represent the three themes accompanied by sub-parts of each theme.

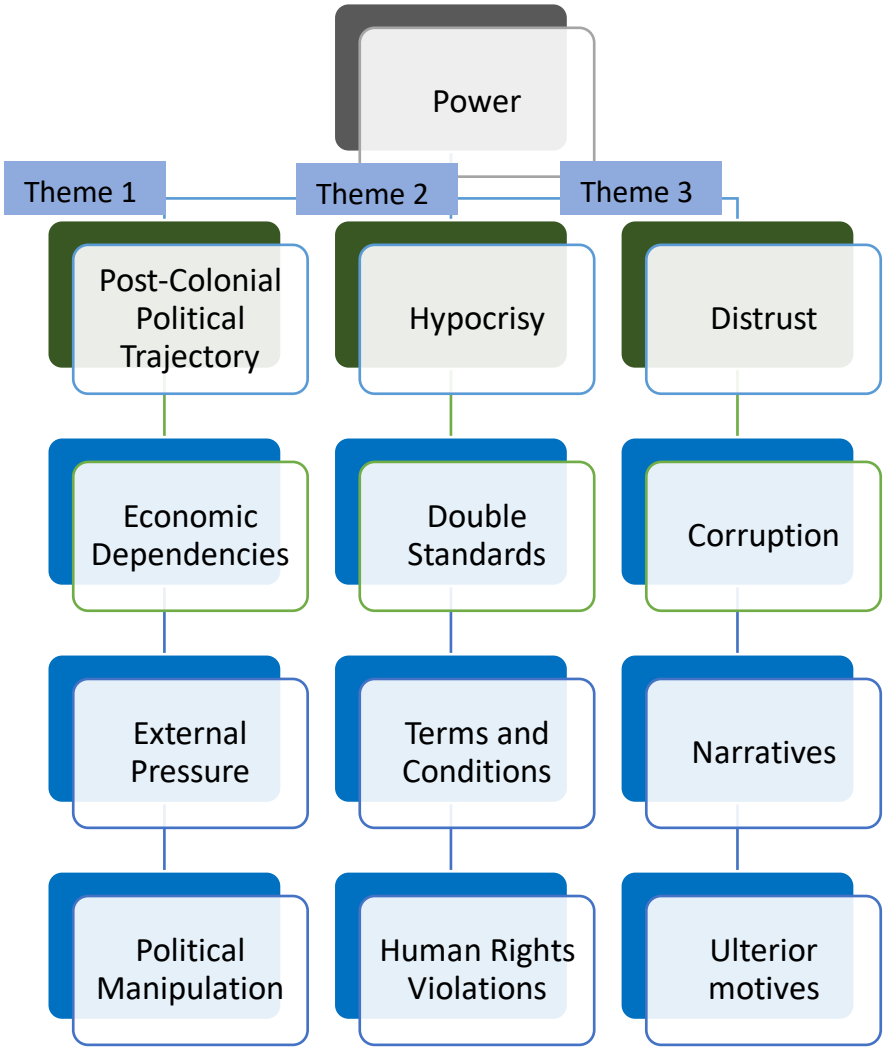

Figure 1: Thematic Framework of properties and dimensions driving power dynamics in global health.

Theme 1: Post-colonial Political Trajectory

This theme describes the developmental course of newly formed states in countries following territorial independence. Participants described post-colonial political trajectory in 3 key properties: economic dependencies, political manipulation, and external pressures in relation to how global health is operationalized in their countries of origin.

Economic Dependency

Economic dependency was described across all participants as a reliance on foreign financial support for development. This concept was discussed in terms of how formerly colonized governments depend on western funding schemes in order to meet the basic needs of the country. For instance, participants described their country's development needs as a challenge to securing adequate investment on healthcare in relation to meeting the universal healthcare guidance from the World Health Organization (WHO).

"Well, our needs are many. Education is calling, social infrastructure. railways requiring our attention. What we generate is also probably not enough so there's always something. It's like being a parent and earning a fixed income but every year you keep having children, after a while all you try to do is to keep them alive. So that's literally what's happening." P4

Formerly colonized countries are still recovering from oppressive regimes with limited resources. Competing priorities such as basic infrastructure, paying off loans, paying salaries, in addition to meeting WHO guidelines does not leave much room to make any significant changes, until outside funding becomes available again. Another participant spoke about their country's inability to fund pressing local public health programs because their currency is controlled by a western country.

"I'll give you an example, CFA Franc is very raw when compared to Euro or Dollar or other currencies. When I say that the local representatives or different organizations within the country cannot provide funding this is because this system can't really fund the Public Health program because the currency is controlled by a western country.. we don't have independence in terms of monetary independence." P5

Political Manipulation

Formerly colonized local governments often center their political campaign on expansion projects in underdeveloped regions to secure votes or attract international praise during highly publicized commissioning ceremonies. One participant talked about the practice of campaign officials starting projects in an election year with allocated funding but failing to complete them due to demands of meeting other priorities in the country.

"Since there was no government facility in the district, it was a major political plus for whoever commissions a hospital. I mean the people will not care whether it's completed or not once it's commissioned, it swings votes and so that's what happened it was quickly painted when it wasn't done and handed over and we literally began with it empty." P4

Funding halts after a project has begun may produce future roadblocks in healthcare access for communities. Previously allocated funds may become depleted, transferring the burden onto health providers and facility staffs. For example, a scarcity in beds, medicines storage or personnel may incur outside costs for operation of the facilities. All of which have the potential to create long-term implications for global health activities.

External Pressure

This concept was discussed according to disease specific global health targets. Participants described their country's inability to support national health programs in accordance with global standard-setting. Participants spoke about the practice of imposing global level protocols or guidelines on communities without consideration of local evidence or input. In terms of global burden of disease, exercising foreign policy was mentioned as a form of compelling countries to accept aid for HIV/AIDs management. For instance, a participant talked about their country's incessant position as a recipient of aid for the national HIV program, explaining that the ministry of health cannot refuse foreign assistance because of the amount of money that is going to be put into the program.

Theme 2: Hypocrisy

Hypocrisy was a pervasive theme across contributions from all participants and was identified in various forms within the global health programming and implementation processes. Three dimensions of hypocrisy were described in terms of double standards, terms and conditions, and human rights violations.

Double Standards

Double standards were discussed as a set of principles or standards that were upheld in one context but not in another. In relation to meeting global health priorities in LMICs as compared with HICs, participants reflected on their experience as implementing partners before traveling to the U.S. for their program. They outlined WHO guidelines for childhood vaccinations and HIV/AIDs drug and treatment regimens as global health specific issues. Using

the latter to frame the conversations, they illustrated different standards for Americans on HIV/AIDs treatment regimens and levels of tolerance on vaccine hesitancy between HICs and LMICs. One participant depicts this form of hypocrisy by highlighting the conditions of choice and decisions surrounding childhood vaccinations for HIC compared to LMICs.

"Look at the US for example the issue of vaccinations you know they have healthcare providers themselves that are also convinced that parents or people should have a choice of whether to vaccinate their children or not but when you come to Africa it's a different story. We get donations of vaccines and we are given a target that you should have vaccinated this community. 95% of these children should be vaccinated but if the donors are coming to Africa with a different set of standards that they are not applying to their own people that raises that mistrust you know, and people start wondering but why?" P2

Another piece of evidence demonstrated how partnerships with HIC and LMICs push collaboration but fall short of addressing health priorities of interest to LMICs. Furthermore, when it comes to global agenda-setting, particularly for Covid-19, LMICs contributions were sidelined.

"It's somehow hypocritical that you would ask for a voice but also not lend a hand and that seems more like the story of those of us in LMICs or where they call the developing countries, that we kind of always are up in arms but are unable to make the necessary contributions where it matters." P1

Terms and Conditions

Participants talked about this dimension in the context of receiving aid with a price. This "price" involved more reporting, more dependence on outside guidelines or protocols, some benefit to the funding body, and a lack of autonomy in decision making. One participant eloquently illustrated this concept linking it with foreign aid.

"I think that there are some people that are using it as foreign policy. To say I'm giving you this, so you need to be giving us something back, so you want value for your money, and I think that is where now a lot of our donors and governments are, when they give foreign aid to other countries, they want something in return, so it's not free and so it comes now with a lot of terms and conditions" P2

The price associated with receiving aid in the wider picture aligns with sustaining a culture of dependency. All participants reflected on their country's position in relation to the west and how it is typically a transactional relationship rather than a partnership.

Human Rights Violations

This dimension elucidated examples of undignified treatment during HIC and LMIC partnerships, bureaucratic protocols on HIV/AIDs treatment and counseling, and behavioral misconduct of HIC global health officials in LMIC settings. An exemplar account of this surfaced in comparing HIV/AIDs counseling and treatment guidelines for African countries versus the United States.

"Human rights are now sort of sidelined for example if you look at HIV treatment we were at a point where everyone who is testing positive, there was a big push to start that person right away on treatment then I get to the US and I find out that oh no HIV treatment is something

that people still can go and think about no one is being forced to take treatment right away but we're saying that we want to end AIDs globally so why is it important for African countries to end it immediately when it's not the same for you?" P6

Another example discussed the intricacies of holding HIC global health actors accountable to alleged sexual assault or unprofessionalism in LMIC locations. This participant explained that by nature of the relationship, LMICs are poorer economically in comparison to HICs and that their national government cannot really take further action to investigate or punish misconducts when they (LMICs) are already in a vulnerable situation. Foreign NGO's proximity to power and privilege can also protect them from being held accountable by national governments. This dimension illustrates delicate obstacles between international partnerships regarding the human right to full self-governance and sovereign equality.

Theme 3: Distrust

Participants demonstrated how distrust functions in global health, through narratives, corruption, and evidence of ulterior motives.

Narratives

This concept was described in relation to how LMIC health actors perceived themselves compared to the western world, how that perception is reflected in society, the language used in media coverage of disease outbreaks in LMICs, capacities of local global health actors, and the narrators of LMIC stories. In the context of decolonizing global health, participants perceptions were voiced according to how they experience these concepts in their daily work as global health actors from LMICs.

Corruption

Corruption was described across both contexts of LMIC and HIC global health settings. This concept was illustrated through program funding provision, resource distribution and practices of nepotism. One piece of evidence talked about the perceived fear of funding allocation directly to local organizations attached to accusations of corruption in developing countries. Participants recognized that historical events of corrupt governments in developing countries remained in the public eye. Practices of hiring biases among top officials in the WHO and UN were also mentioned. For instance, one participant spoke about global health leadership practicing corruption but not held accountable because of their position as well as their reputation within the organization.

"*I don't really trust the UN or WHO. These are programs that we should be looking up to but I think there's a lot of corruption within WHO and it really depends on the country where the WHO program personnel are, or if someone within WHO has authority over the regional office." P3*

The following illustrative quote details a practice consistent with descriptions of aid linked to stipulations outside of the recipient's control.

"An example is if USAID decide today to give funding for malaria program or HIV this funding will go through many NGOs before reaching the country so it will come in the country in terms of programs used by many NGOs. So, they use their own staff and use the money which is provided for the country and when they finish everything, they take the money back to their country" P5

Ulterior Motives

Ulterior motives were a dimension of mistrust connected to aspects of foreign policy and fulfilling western interests in LMIC and HIC partnerships. Participants discussed concerns about NGOs presence in LMICs as establishing job opportunities for HICs, extracting already scarce resources, and exercising soft power. One piece of evidence illustrated how NGO's operation in LMICs fuel western economies.

"All of these things are related to political situation you know, if there is unemployment in Europe and people need to work. this is the way they use us, well… because this is the way they use to continue to work because they keep us in this position to develop their country" P4

Participants also described the internal operations of NGOs in connection to data and intel collection.

What is decolonizing global health to you?

Each participant answered to the question of what decolonizing global health would mean to them, as practicing global health actors situated in LMICs. Particularly, "*What implications would a decolonized global health look like in their respective countries?"* All participants agreed that global health contributions are presently not equal, and that equal contribution would entail greater engagement with local communities to help shift dominant perspectives, require flexibility in donor requirements, incorporate meaningful dialogue to better understand HIC and LMIC challenges, and would encourage intentional systems of

capacity building. The following table highlights what aspects of global health may be assessed for decolonizing global health.

Recommendations: *How do LMIC global health actors envisage a decolonized global health?*	
Shift in perspectives	• Equal contribution • Shared Ownership • Holistic approach involving people
Flexibility in donor requirements	• Tailored funding to national priorities/capacities • Considers of social determinants of health
Meaningful dialogue	• Addressing corruption and politics • Deep acknowledgement of colonial harms • Educating the next generation
Intentional capacity building	• Communities should be involved from planning stages of a project or intervention • Understanding local capacities in context

Table 1: Resulting recommendations of what decolonizing global health would entail for LMIC global health actors.

Discussion

Evidence from literature and the lived experiences of global health actors from developing countries corroborate existing inequities within global health research and practice. Participants revealed examples of how these inequities show up in their work as

implementation partners. Additionally, while attention is growing on decolonizing global health, perspectives from the global south are critical in ensuring tangible resolutions that are in line with discussions and decisions surrounding the movement.

Participant interviews revealed three key dimensions operating to sustain unequal power dynamics among international partnerships. The existing global health system is rooted in colonial ideologies which influence hypocritical international health policies and practices, that are compounded by experiences that uphold mistrust between HIC and LMIC partnerships in global health. This illustrates a growing case for the importance of meaningful change within global health's current paradigm. Figure 2 demonstrates how the three themes correspond to each other to sustain the status quo within global health.

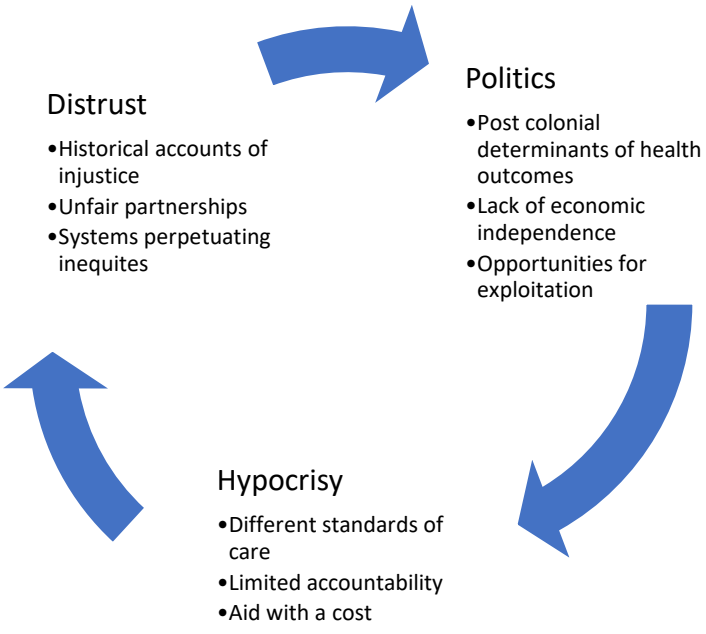

Figure 2: Mechanistic representation of the identified components within global health that sustain power dynamics among HIC and LMIC partnerships.

Post-colonial Political Trajectory "Global Health is a political football"

Based on participant interviews, the post-colonial political trajectory theme underscores inherited colonial states and practices. The impact of colonial domination influenced cultural, economic, political, and social conditions that global health currently operates within (Keller, 2006). As participants described the challenges they must overcome in global health partnerships as well as implementation in formerly colonized nations, they drew connections between similar challenges within global health's architecture. Specifically, the act of subordinating global south expertise.

This dimension is particularly useful in that it uncovers permanent domestic and international power relationships through economic dominance and the influence of HICs in global agenda-setting. It is common practice in global health agenda-setting to establish guidelines and protocols that may be adapted accordingly by countries (Prah Ruger et al., 2014). But initial covid-19 guidelines were visibly designed from HIC perspectives, including social distancing, hand washing, and masking measures that did not consider an estimated 835 million inhabitants of informal housing, 3 billion lacking handwashing facilities, and the 689 million living in extreme poverty (*1 in 3 People Globally Do Not Have Access to Safe Drinking*

Water – UNICEF, WHO, n.d.) (*Global Poverty: Facts, FAQs, and How to Help | World Vision*, n.d.).

These power relationships can be found in very contemporary examples, including in the management of COVID-19 globally and the COVID-19 vaccine roll-out. In the COVID-19 global vaccine distribution, 51% of the vaccines were quickly reserved and purchased by HICs as of November 2020, meanwhile many LMICs had only reached agreements with 6 out of the 13 manufacturer candidates (So & Woo, 2020). Additionally, LMICs were not able to procure any mRNA vaccines (Pfizer and Moderna) as they require cold chain storage and distribution which are not readily accessible in many LMICs (*Pfizer and BioNTech Submit COVID-19 Vaccine Stability Data at Standard Freezer Temperature to the U.S. FDA | Pfpfizeruscom*, n.d.). Consequently, global health analysts warned that one-quarter of the world may not receive the vaccine until 2022 (*Global COVID-19 Vaccine Access: A Snapshot of Inequality | KFF*, n.d.) , again exposing glaring inequalities within a pandemic that purportedly is the great equalizer. The management of COVID-19 has demonstrated that agendas, recommendations, and priorities are designed from the lens of HICs. As participants noted, formerly colonized countries are already economically disadvantaged and hence powerless in the global sphere.

Grippingly, political manipulation which is a form of control, is exercised by formerly colonized countries today, often major frustrations to both local and foreign global health programs in the global south. Participant's description of local challenges with politics brought

about critical elements in newly formed nation states following colonial rule. Firstly, as Aimé Césarie's writings demonstrates, post-colonial governments modeled western imposed mockups of democracy which haven't always proved to be stable (Viveros-Vigoya, M.,2020). For instance, post-colonial governance was often met with ethnic strife and conflict, entrenched in divided identity groups due to artificial boundary lines that were created during the Partition of Africa (Ramage, 1899). A participant drew on this context to describe the limited capacity of humanitarian agencies when implementing global health projects in conflict zones. Along with the threat of violence to both local and foreign healthcare providers, politics in formerly colonized countries embrace colonial forms of domination by inflicting violence from one group to another (Blanton et al., 2001).

Hypocrisy "We say we're a global village now, but the donor countries have superior drugs"

Moral psychology interprets hypocrisy as a failure to model standards or principles that one claims to have or believe in (Graham et al., 2015). Participants discussed ways hypocrisy is reflected within the field of global health by illustrating that global health language and actions do not always align.

Examples of hypocrisy that are prevalent across the field of global health are evidenced through transactional partnerships (Lawrence & Hirsch, 2020). Partnership and collaboration are the cornerstones to global health activities (*Global Health Partnerships: Assessing Country Consequences*, 2005). However, these touted relationships are often unfair and benefit HIC partners more than LMIC partners. Crane (2010) raises the issue of global health operating

paradoxically; on one hand, it relies on partnerships with LMICs to generate knowledge and meet health and research needs, and in the same breath, it exploits these relationships by dictating the very bodies of knowledge produced. It is no surprise then that HICs benefit from health disparities, since they make global health programs both desirable to students and in demand, effectively marking the value of inequality. Evidently, the global village that is portrayed in communication is at odds with reality.

Participants noted that aid came with conditions that keep LMICs dependent on outside funding. To borrow the words of Akugizibwe, funding from HICs come with purse strings often attached to research or program priorities of HICs rather than LMIC communities (Akugizibwe, 2020). Consequently, it permits global health organizations in HICs to prioritize donor interests rather than communities (Lawrence & Hirsch, 2020). However, disengaged communities affect project implementation processes which in turn affect, program indicators and ultimately the integrity of a project.

It is increasingly evident that the global health face is largely white male, heavily dependent on black women in unpaid roles, and primarily led by former colonizers. Leadership positions which qualify decision-making on global health research, program, and practice reinforce colonial institutional norms through systemic discrimination and stereotyping (Büyüm, Kenney, Koris, Mkumba, & Raveendran, 2020). Detrimental functions of colonialism are tied to racism which is omnipresent in global health language and institutions (Erondu et al., 2020). Global health academia, research, and implementation are fraught with racist ideologies which manifest in the very inequalities the field supposes to dismantle.

A recent example of colonial culture within global health was when a viral video captured barefaced racism in a discussion among two French doctors. They suggested that vaccines for the coronavirus should first be tested on African people stating, *"It may be provocative. Should we not do this study in Africa where there are no masks, no treatment or intensive care, a little bit like it's been done for certain AIDS studies, where among prostitutes, we try things, because we know that they are highly exposed and don't protect themselves?"* ((7) French Doctors Suggest Testing Covid-19 Vaccine in Africa, Slammed as Racist - YouTube, n.d.)This discussion between Jean-Paul Mira and Camille Locht demonstrated how colonial mentalities influence ideas about race and who is unworthy of dignified treatment. The timing (amid protests over George Floyd's death and a global pandemic) and package of these comments resurfaced painful reminders of indigenous peoples struggle for equal treatment and representation.

Distrust

The complex chasm of distrust between HICs and LMICs has widened in the last decade (*American Fake Doctor in Uganda Blamed for Deaths of 105 Children — Quartz Africa*, n.d.) (*UN Health Agency: Rising Misconduct Reports Are "positive" - ABC News*, n.d.)(Keijzer & Lundsgaarde, 2017). Suspicions of ulterior motives emerged as participants noted that NGO's presence in LMICs establish jobs for HICs as well as their influence of employment of nationals. A 2017 conference on unintended effects of international cooperation revealed that over a million national staff were working for foreign aid funded agencies (Keijzer & Lundsgaarde,

2017). It is important to acknowledge the double impact of foreign presence within the context of colonialism. As participants articulated and evidence supports, not only do foreign organizations reaffirm the presence of HICs control in LMICs, but they motivate western exceptionalism by attracting employment from local actors, which affect the national workforce in LMICs (Lemay-Hebert, N., Marcelin, L.H., Pallage, S. and Cela, T., 2020).

Another instance of distrust was exemplified by corruption from HIC global health organizations. Corruption amongst global health leadership were raised and juxtaposed to forms of corruption within LMIC governments. Interestingly, conversations about corruption in global health fail to assess how corruption is embedded within health systems. While corruption is often cited as a threat to economic development in LMICs, it disregards historical and political basis in abuses of power (*The Economic Impact of Colonialism | VOX, CEPR Policy Portal*, n.d.). The impact of colonial domination created the regressive conditions that global health practitioners confront today.

More evidence illustrates that less than 2% of funds from humanitarian organizations are directly allocated to local NGOS (*Less than 2% of Humanitarian Funds "go Directly to Local NGOs" | Working in Development | The Guardian*, n.d.). Additionally, almost 80% of USAID grants go to American firms (*As a System, Foreign Aid Is a Fraud and Does Nothing for Inequality | Kenan Malik | The Guardian*, n.d.). Increasingly, foreign policy has been used to influence global health funding priorities (Kevany, 2016). This practice is corroborated by the growing use of health interventions as a tool to improve security, bolster international image, and influence diplomacy (Feldbaum et al., 2010). As participants pointed out, aid intended to improve health

outcomes in local communities are filtered through programming from foreign organizations and exertion of power by influencing local governments (*World Disasters Report – Chapter 4 | IFRC Campaigns*, n.d.).

Damaging narratives about LMICs or developing countries are mimicked in the global community (*"Shithole Countries" Is Shorthand for a Racist Hierarchy - The Atlantic*, n.d.)(*Coronavirus: France Racism Row over Doctors' Africa Testing Comments - BBC News*, n.d.). However, many of the ill-informed mainstream narratives about LMICs are a result of colonial disruptions (Klein & Rodney, 1974). So pervasive is the practice of devaluing LMIC's contributions in global health that a BMJ article titled "How (not) to write about global health" highlighted common semantics, and practices within global health that fail to advance equity and justice (Jumbam, 2020). The article draws from a well-known Granta satirical article which presents common narratives about Africa packaged in literature, media, and other dissemination platforms (*How to Write About Africa | Binyavanga Wainaina | Granta*, n.d.).

Final Remarks

Fanon's work on the colonized and the colonizer in *Black skin, White masks* explore the psychological impact of dehumanization which are instructive to examining power imbalances within unequal relationships (Frantz, 2017). Within global health, power can be understood as the ability to influence and control humans, knowledge, financial, and material resources to achieve a desired outcome (Keller, 2006). By virtue of colonialism, power is reflected through social, economic, and political relationships between HIC and LMICs. Considerable pieces of evidence demonstrate that global health's current framework need to address power imbalances to reach equity in global health.

Limitations

This study was qualitative in nature and intended to elucidate the perspectives of the participants. Limited published literature on studies investigating decolonizing global health from LMIC perspectives provided little guidance on the best approach to data collection strategies. Another limiting factor was the small sample size which may have influenced variation represented in participant responses. Additionally, Humphrey Fellows may not represent the full range of LMIC perspectives that ideally a heterogenous sample with respect to global health career stage would provide. Despite these identified limitations, the following conclusions can be drawn with confidence.

Conclusion

As increasing calls to decolonize global health receive attention, it is vital to first understand what decolonizing global health is from global health actors in formerly colonized regions. This study revealed new insight on how politics, hypocrisy, and distrust among HIC and LMIC partnerships correspond to uphold power imbalances posing the largest threat to global health equity. Recommendations on decolonizing global health involve a shift in perspectives, flexibility in donor requirements, meaningful dialogue, and intentional capacity building. These key areas offer an opportunity to privilege LMIC contributions in global health research and policy. Further research is needed to understand the depth and scale of the structures impeding global health's aim to achieve health equity worldwide. Future studies should also examine in detail the role of colonialism as a social determinant of health. A deeper awareness and critical examination of the past will not only help us understand the present, but it will also inform our model for achieving health equity.

References

Beaglehole, R., & Bonita, R. (2010). What is global health?. *Global health action*, *3*, 10.3402/gha.v3i0.5142. https://doi.org/10.3402/gha.v3i0.5142

(7) French doctors suggest testing Covid-19 vaccine in Africa, slammed as racist - YouTube. (n.d.). Retrieved May 1, 2021, from https://www.youtube.com/watch?v=w2GzVKGN1W4

1 in 3 people globally do not have access to safe drinking water – UNICEF, WHO. (n.d.). Retrieved April 27, 2021, from https://www.who.int/news/item/18-06-2019-1-in-3-people-globally-do-not-have-access-to-safe-drinking-water-unicef-who

Abimbola, S. (2019). The foreign gaze: Authorship in academic global health. *BMJ Global Health*, *4*(5), 1–5. https://doi.org/10.1136/bmjgh-2019-002068

Abimbola, S., & Pai, M. (2020). Will global health survive its decolonisation? *The Lancet*, *396*(10263), 1627–1628. https://doi.org/10.1016/S0140-6736(20)32417-X

American fake doctor in Uganda blamed for deaths of 105 children — Quartz Africa. (n.d.). Retrieved April 27, 2021, from https://qz.com/africa/1688906/american-fake-doctor-in-uganda-blamed-for-deaths-of-105-children/

As a system, foreign aid is a fraud and does nothing for inequality | Kenan Malik | The Guardian. (n.d.). Retrieved April 27, 2021, from https://www.theguardian.com/commentisfree/2018/sep/02/as-a-system-foreign-aid-is-a-fraud-and-does-nothing-for-inequality

Badejo, O., Sagay, H., Abimbola, S., & Van Belle, S. (2020). Confronting power in low places: historical analysis of medical dominance and role-boundary negotiation between health professions in Nigeria. *BMJ Global Health*, *5*(9), e003349. https://doi.org/10.1136/bmjgh-2020-003349

Blanton, R., Mason, T. D., & Athow, B. (2001). Colonial Style and Post-Colonial Ethnic Conflict in Africa. In *Source: Journal of Peace Research* (Vol. 38, Issue 4).

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

Büyüm, A. M., Kenney, C., Koris, A., Mkumba, L., Raveendran, Y., & Operations, C. (2020). Decolonising global health: if not now, when? Commentary. *BMJ Global Health*, *5*, 3394. https://doi.org/10.1136/bmjgh-2020-003394

Chandanabhumma, P. P., & Narasimhan, S. (n.d.). *Towards health equity and social justice: an applied framework of decolonization in health promotion*. https://doi.org/10.1093/heapro/daz053

Coronavirus: France racism row over doctors' Africa testing comments - BBC News. (n.d.). Retrieved April 27, 2021, from https://www.bbc.com/news/world-europe-52151722

Decolonizing Global Health Education: Rethinking Institution... : Academic Medicine. (n.d.). Retrieved September 15, 2020, from https://journals.lww.com/academicmedicine/Abstract/9000/Decolonizing_Global_Health_Education__Rethinking.97193.aspx

Drwecki, B. B. (2015). MEDICAL EDUCATION Education to Identify and Combat Racial Bias in Pain Treatment. In *AMA Journal of Ethics* (Vol. 17). www.amajournalofethics.org

Eichbaum, Q. G., Adams, L. V., Evert, J., Ho, M.-J., Semali, I. A., & van Schalkwyk, S. C. (2020). Decolonizing Global Health Education. *Academic Medicine*, *Publish Ah*.

https://doi.org/10.1097/acm.0000000000003473
Erondu, N. A., Peprah, D., & Khan, M. S. (2020). Can schools of global public health dismantle colonial legacies? *Nature Medicine*, *26*(10), 1504–1505. https://doi.org/10.1038/s41591-020-1062-6
Feldbaum, H., Lee, K., & Michaud, J. (2010). *Global Health and Foreign Policy*. *32*. https://doi.org/10.1093/epirev/mxq006
Frantz, F. (2017). Black skin, white masks. In *Black Skin, White Masks*. https://doi.org/10.4324/9781912282616
Frenk, J., & Moon, S. (2013). Governance Challenges in Global Health. *New England Journal of Medicine*, *368*(10), 936–942. https://doi.org/10.1056/NEJMra1109339
Global COVID-19 Vaccine Access: A Snapshot of Inequality | KFF. (n.d.). Retrieved April 27, 2021, from https://www.kff.org/policy-watch/global-covid-19-vaccine-access-snapshot-of-inequality/
Global Health 50/50. (2020). *Power, privilege and priorities*. 115. https://globalhealth5050.org/wp-content/uploads/2020/03/Power-Privilege-and-Priorities-2020-Global-Health-5050-Report.pdf
Global Health Partnerships: Assessing Country Consequences. (2005). www.mckinsey.com
Global poverty: Facts, FAQs, and how to help | World Vision. (n.d.). Retrieved April 27, 2021, from https://www.worldvision.org/sponsorship-news-stories/global-poverty-facts#facts
Graham, J., Meindl, P., Koleva, S., Iyer, R., & Johnson, K. M. (2015). When Values and Behavior Conflict: Moral Pluralism and Intrapersonal Moral Hypocrisy. *Social and Personality Psychology Compass*, *9*(3), 158–170. https://doi.org/10.1111/spc3.12158
Greene, J. (2016). *Colonial Medicine and Its Legacies*. *September*.
Hanefeld, J. (2008). How have Global Health Initiatives impacted on health equity? *Promotion & Education*, *15*(1), 19–23. https://doi.org/10.1177/1025382307088094
Headrick, D. R. (2014). Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900-1940. *PLoS Neglected Tropical Diseases*, *8*(4). https://doi.org/10.1371/journal.pntd.0002772
Herrick, C. (2017). The strategic geographies of global health partnerships. *Health and Place*, *45*, 152–159. https://doi.org/10.1016/j.healthplace.2017.03.017
Hirsch, L. A. (2021). Is it possible to decolonise global health institutions? *The Lancet*, *397*(10270), 189–190. https://doi.org/10.1016/S0140-6736(20)32763-X
Holden, K., Akintobi, T., Hopkins, J., Belton, A., McGregor, B., Blanks, S., & Wrenn, G. (2016). Community engaged leadership to advance health equity and build healthier communities. In *Social Sciences* (Vol. 5, Issue 1). MDPI AG. https://doi.org/10.3390/socsci5010002
How to Write About Africa | Binyavanga Wainaina | Granta. (n.d.). Retrieved April 27, 2021, from https://granta.com/how-to-write-about-africa/
Jumbam, D. T. (2020). How (not) to write about global health. In *BMJ Global Health* (Vol. 5, Issue 7, p. e003164). BMJ Publishing Group. https://doi.org/10.1136/bmjgh-2020-003164
Keijzer, N., & Lundsgaarde, E. (2017). *When "unintended effects" reveal hidden intentions: Implications of "mutual benefit" discourses for evaluating development cooperation*. https://doi.org/10.1016/j.evalprogplan.2017.09.003
Keller, R. C. (2006). Geographies or power, legacies of mistrust: Colonial medicine in the global present. *Historical Geography*, *34*, 26–48.

Kendall, G., Wickham, G., Seale, C., Miller, R. L., Bloor, M., Frankland, J., Robson, T. K., Prior, L., Mainela-arnold, E., Alibali, M. W., Hostetter, A. B., Evans, J. L., Ravanis, K., & Models, P. (2019). *Constructing Grounded Theory* (Vol. 7, Issue January).

Kevany, S. (2016). Global Health Diplomacy, "San Francisco Values," and HIV/AIDS: From the Local to the Global. *Annals of Global Health*, *81*(5), 611. https://doi.org/10.1016/j.aogh.2015.12.004

Kim, D. T. (2014). Paul Farmer, Jim Yong Kim, Arthur Kleinman, and Matthew Basilico (eds.): Reimagining global health: an introduction. *Theoretical Medicine and Bioethics*, *35*(6), 463–468. https://doi.org/10.1007/s11017-014-9306-4

Klein, M. A., & Rodney, W. (1974). How Europe Underdeveloped Africa. *The International Journal of African Historical Studies*, *7*(2), 323. https://doi.org/10.2307/217137

Lavery, J. V., Green, S. K., Bandewar, S. V. S., Bhan, A., Daar, A., Emerson, C. I., Masum, H., Randazzo, F. M., Singh, J. A., Upshur, R. E. G., & Singer, P. A. (2013). Addressing Ethical, Social, and Cultural Issues in Global Health Research. *PLoS Neglected Tropical Diseases*, *7*(8), 6–10. https://doi.org/10.1371/journal.pntd.0002227

Lavery, J. V, & Ijsselmuiden, C. (2018). *The : Filling a critical gap in global Research Fairness Initiative research ethics [version 1; referees: 2 approved]*. *0*, 1–11. https://doi.org/10.12688/gatesopenres.12884.1

Lawrence, D. S., & Hirsch, L. A. (2020). Decolonising global health: transnational research partnerships under the spotlight. *International Health*, *12*, 518–523. https://doi.org/10.1093/inthealth/ihaa073

Less than 2% of humanitarian funds "go directly to local NGOs" | Working in development | The Guardian. (n.d.). Retrieved April 29, 2021, from https://www.theguardian.com/global-development-professionals-network/2015/oct/16/less-than-2-of-humanitarian-funds-go-directly-to-local-ngos

Pfizer and BioNTech Submit COVID-19 Vaccine Stability Data at Standard Freezer Temperature to the U.S. FDA | pfpfizeruscom. (n.d.). Retrieved April 27, 2021, from https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-submit-covid-19-vaccine-stability-data

Pinto, A. D., & Upshur, R. E. G. (2007). *GLOBAL HEALTH ETHICS FOR STUDENTS*. https://doi.org/10.1111/j.1471-8847.2007.00209.x

Prah Ruger, J., Yach, D., & Health Gov Author manuscript, G. (2014). *The Global Role of the World Health Organization* (Vol. 2, Issue 2).

Ramage, B. J. (1899). *Source: The Sewanee Review* (Vol. 7, Issue 2). https://about.jstor.org/terms

Report 2020 – Global Health 50/50. (n.d.). Retrieved January 21, 2021, from https://globalhealth5050.org/2020report/

"Shithole Countries" is Shorthand for a Racist Hierarchy - The Atlantic. (n.d.). Retrieved April 27, 2021, from https://www.theatlantic.com/politics/archive/2019/01/shithole-countries/580054/

So, A. D., & Woo, J. (2020). Reserving coronavirus disease 2019 vaccines for global access: Cross sectional analysis. *The BMJ*, *371*. https://doi.org/10.1136/bmj.m4750

Stapleton, G., Schro, P., Laaser, U., Meershoek, A., & Popa, D. (2014). To Prominent Theories and Relevant Topics. *Global Health Action*, *1*, 1–7.

The activists trying to "decolonize" global health | Devex. (n.d.). Retrieved September 29, 2020,

from https://www.devex.com/news/the-activists-trying-to-decolonize-global-health-94904
The economic impact of colonialism | VOX, CEPR Policy Portal. (n.d.). Retrieved April 27, 2021, from https://voxeu.org/article/economic-impact-colonialism
The Lancet Global Health. (2020). Decolonising COVID-19. In *The Lancet Global Health* (Vol. 8, Issue 5, p. e612). Elsevier Ltd. https://doi.org/10.1016/S2214-109X(20)30134-0
Tuck, E., & Yang, K. W. (2012). Decolonization is not a metaphor York at New Paltz. In *Decolonization: Indigeneity, Education & Society* (Vol. 1, Issue 1).
UN health agency: Rising misconduct reports are "positive" - ABC News. (n.d.). Retrieved April 27, 2021, from https://abcnews.go.com/Health/wireStory/health-agency-rising-misconduct-reports-positive-60464523
Vectors of Death : The Archaeology of Eu-. (n.d.).
Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. In *American Journal of Public Health* (Vol. 93, Issue 2, pp. 200–208). American Public Health Association Inc. https://doi.org/10.2105/AJPH.93.2.200
World Disasters Report – Chapter 4 | IFRC campaigns. (n.d.). Retrieved April 27, 2021, from http://ifrc-media.org/interactive/1248/
Assenova VA, Regele M. Revisiting the effect of colonial institutions on comparative economic development. *PLoS One*. 2017;12(5). doi:10.1371/journal.pone.0177100
Roeder, A. (2019, April 10). Challenging the status quo in global health. Retrieved February 21, 2021, from https://www.hsph.harvard.edu/news/features/decolonizing-global-health/
Harvard T.H. Chan School of Public Health – "Decolonizing Global Health: A Student Conference at the Harvard T.H. Chan Public Health School" held on February 8, 2019 in Boston, Massachusetts.