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Global Health, Participation, and Empowerment: 'Decolonising' Global Health

Abstract
As often happens with concepts that traverse the academy and popular culture, decolonisation has become a buzzword and, in the process, it has amassed new meanings. It has therefore become increasingly important to situate the decolonisation debate, including within the global health space. In this brief chapter, we introduce the colonial/decolonial duality, and offer conceptual clarification alongside problematising the current structures and barriers to participation for previously colonised communities. We then highlight the need to dismantle structures that are grounded on and uphold coloniality and suggest pathways towards rebuilding a more equitable global health space through employing the principle of subsidiarity. To this end, we propose a framework that is imagined as a deliberative and dialogic tool that can be instrumental for actors within the global health space to navigate their way towards decolonial futures.

Zusammenfassung
Wie so oft bei Konzepten, die in Wissenschaft und Populärkultur weit verbreitet sind, ist auch der Begriff *Dekolonialisierung* zu einem Schlagwort geworden, mit dem sich neue Bedeutungen verbinden. Daher ist es zunehmend wichtig geworden, die Dekolonialisierungsdebatte auch im Bereich globaler Gesundheit zu verorten. In diesem kurzen Kapitel führen wir zunächst in das Begriffspaar *colonial/decolonial* ein und problematisieren die aktuellen Strukturen und Hindernisse für die Beteiligung ehemals kolonisierter Gemeinschaften. Anschließend betonen wir die Notwendigkeit, jene Strukturen des Global Health Zusammenhangs zu dekonstruieren, die auf Kolonialität basieren und diese Muster aufrechterhalten, und plädieren für eine Anwendung des Subsidiaritätsprinzips, mithilfe dessen sich ein dekolonialisierter, gerechterer globaler Gesundheitsraum verwirklichen ließe. Zu diesem Zweck entwerfen wir einen Rahmen, der als deliberatives und dialogisches Instrument gedacht ist und der Akteuren im globalen Gesundheitsraum als Orientierung auf dem Weg in eine dekoloniale Zukunft dienen kann.

1 Introduction/Background

As often happens with concepts that traverse the academy, disciplines, popular culture and diverse institutions, decolonisation has become a buzzword. In its oscillation between the academy and popular culture, it has in some spaces, amassed new meanings. Amidst the work of decolonial scholars who have tried to bring conceptual clarification (cf. Mignolo/Walsh 2018; Ndlovu-Gathsheni 2018), we find other views, bound to incomplete theorisations and fragmentary understandings of

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socio-political and cultural changes that have muddied the conceptual waters by mislabelling any and all challenges to the status quo as decolonisation. The sum is a risk of decolonisation becoming something of a *creep concept*, too open to mean anything, and by extension too easy to weaponize in defence of imperialist logic (cf. Haslam et al. 2021; Atuire 2023).

The decolonial project, in our view, is a process that did not end with the gaining of independence of formerly colonised territories, but an ongoing project towards dismantling current structures of inequity premised on colonialism and repairing the systemic and protracted harms that colonised peoples have suffered. We focus our efforts on the decolonisation of global health because as a field it is concerned with the "praxis of living" and as a phenomenon it occurs in a way "where determinants of health or health outcomes circumvent, undermine or are oblivious to the territorial boundaries of the state" (Stapleton et al. 2014, 1). Nested within global health is a shift beyond the domesticity of public health to include international players. It provides a rich analytical ground for decolonial scholarship and holds much hope for negotiating a more liberatory and participatory space that can readily extend to the other disciplines that constitute global health's various components such as sociology, global governance, medicine, ethics and economics (cf. Mignolo/Walsh 2018, 137).

By centring the right to health and a corresponding right to life, we are able to lean into the argument that we have, in theory, collectively settled against the hierarchisation of human life, marked by the end of the colonial era that brought about political independence across ex-colonies. A decolonial lens troubles the legacy of colonialism, maps its praxical contours and the ways in which it insists on the hierarchisation of human value in this post-colonial era. Embedded within the decolonial/decoloniality question are a multitude of questions about equality, equity and ethics within global systems, as well as race and the social determinants of health. Decoloniality also takes to task modernity's neo-liberalist failed promises of progress for those who inhabit ex-colonies and have worked too hard in ailing conditions, expending their health and humanity in service of colonial-esque consumption and dying too soon – this too is a global health problem.

Colonialism and its continued legacy have so profoundly shaped the lives and livelihoods of peoples across many regions of the global south that any attempt at improving the health of people living in these areas

cannot be oblivious to this historical and current experience. The very borders and agglomeration of peoples into the countries we know today in many parts of the global south are a result of colonialism.

In this brief chapter, our goal is to conceptually unpack the colonial/decolonial duality (section 2), highlight the need to dismantle structures that are grounded on and uphold coloniality (3) and suggest pathways towards rebuilding a more equitable global health space (4).

2 Conceptual unpacking of colonialism and coloniality in global health

There is often a common misapprehension around what makes colonialism fundamentally wrong that is in part derivative of misplaced analytic emphasis on the morality of forces associated with colonisation such as injustice, oppression, pilfering of resources, racism, and other evils. However, it is possible for communities within countries to become victims of these evils without being colonised (cf. Atuire 2023). Thus, in our analysis, we place our primary focus on the fundamental moral wrong – the subtraction of agency as the precursive wrong that is often succeeded by what then constitutes our secondary level analysis, that is the immoral acts that are often associated with colonialism. Writing on the evils of colonialism, Renzo (2019, 2) explains that colonialism is fundamentally wrong because it "undermines the capacity of political communities to exercise their self-determining agency in a particular way. When political communities are treated in this way, they suffer a distinctive wrong, independently of whether this treatment is accompanied by any of the other crimes." From this understanding, it is clear that debates about *good* and *bad* colonisers become misplaced because the act of colonising is intrinsically immoral. It is in the subtraction of agency that a substitutive power sweeps in to serve the interest of the coloniser, creating a centre (read coloniser) where power resides and a periphery (read colonised) that serves the interests of the centre. Importantly, at the primary level, we are able to draw lines of continuity of a sustained subtraction of agency, even in a post-colonial era. This allows us to highlight the relevance of the decolonial movement within the post-colonial context.

The term post-colonial literally means the period after formal colonisation. Yet even at the dawn of their independence, leaders of newly

independent nations like Ghana's Kwame Nkrumah understood that while the colonial period was behind, it was not firmly so and had begun to bleed into, and undermine post-colonial hopes. To describe this phenomenon, Nkrumah coined the term neo-colonialism in the 1960s, speaking to the fact that in the post-colonial moment, we do not only deal with the consequences of a colonial past, but also with the continuation and reproduction – albeit more covertly – of the structures and relations of extraction, dispossession and imposition between the former colonisers and the colonised peoples (Nkrumah, 1996). In effect, these structures and institutions continue to frame the macro and micro for the majority of previously colonised peoples who endure persistent conditions of colonisation even in the absence of the White coloniser. Colonisation models are thus perpetuated by fellow citizens – economic elites, former colonisers, and other external actors, as well as through institutions of global governance. Quijano (cf. 2000) coined this continuity – coloniality, referring to the ways in which colonial logic manifests in contemporary society, its ordering that is a hierarchisation of human value along racial and ontological, epistemic and linguistic lines. As a system, coloniality does not require the presence of a coloniser because it is embedded in our social structures and processes such that it keeps evolving along colonial lines. Much of the world we live today is predicated on the system of coloniality. The prefix *de* (colonial) as opposed to *post*, underscores and embraces multiple temporalities and rejects the imposition of imperial linearity of progress (Mignolo 2011). It importantly allows us to map lines of colonial continuity and deconstruct colonial logic, its social formations and processes in a post-colonial era to move us toward de-centring the west within the global health arena as a means towards ensuring formerly colonised countries as political communities do not remain colonised through the undermining of their self-determining agency in healthcare by the agency of powers that lie outside their borders and beyond their control (cf. Atuire 2023, 5).

There are multiple ways in which that agency is challenged and/or undermined across global health systems, and these can also be opportunities for reasserting or building in mechanisms to strengthen self-determining agency across localities, in, for example, governance, health-priority setting or community participation. The latter can also be linked to facilitating broad enough conceptualisations of health and incorporating those into the global health system. The World Health

Organization (1948, 16) defines health, "not negatively or narrowly as the absence of disease or infirmity, but positively and broadly as 'a state of complete physical, mental and social wellbeing' the enjoyment of which should be part of the rightful heritage of 'every human being without distinction of race, religion, political belief, economic or social condition'". A similar way of engaging with this expansive notion of health is, according to Nigerian author Gbadegesin (cf. 1991), looking at disease as a state of *dis*-ease such that recovering and maintaining health centres is journeying towards a place of physical, mental and social ease. Conceptualising health in this way has implications for how different populations conceptualise ease at the mental and social levels – and this has a throughline that leads us to bigger conversations about epistemology and the modern biomedical system of health and its dominance within the global health space.

To trouble the issues we have so far raised, we focus on outbreaks such HIV/AIDS, COVID 19 and Monkey-pox (mpox) because they importantly highlight that lives do not matter in the same way across the globe given that all three have been marked by inequity in terms of access to diagnostics, therapeutics and vaccinations. We have to return to the architecture of our conceptions of health and its governing infrastructure within the global arena to scrutinise the idea that the rules of the game of international relations are apolitical and highlight that through the imposition of laws and rules, former colonial powers have been able to maintain hegemony even within the post-colonial context, such that the global health arena is neither a de-politicised nor an apolitical space (cf. Grovogui 1996).

In the case of the HIV/AIDS epidemic, the South African government, with a population devastated by HIV/AIDS, under Mandela's leadership enacted the 1997 Medicines Act, which aimed to amplify availability of generic medicines by increasing their production and reducing retailing price. The US accused South Africa of violating the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement and threatened the country with sanctions. Thirty-nine pharmaceutical companies took the South African government to court in a bid to set a precedent against poorer countries undermining their profits. Public discourse progressively shifted towards scrutinising the ethics of prioritising drug profiteering over human life. The US position grew politically unsavoury, the pharmaceuticals' position untenable. In the meantime, South Africa alone lost 400 000 of its citizens in part due to price-driven inaccess

to medicine. The South African government won the ethical argument, pharmaceuticals dropped the case and paid for the South African government's legal fees (cf. Tegama 2020).

Similarly, during the COVID 19 outbreak in 2020, the South African government alongside India requested a temporary waiver of certain provisions under TRIPS at the World Trade Organisation. The waiver, they argued, would facilitate cost reduction in developing and manufacturing therapeutics, vaccines and diagnostics and enable them to meet their constitutional duty of healthcare provision for their citizens. Whilst the waiver request gained traction amongst low-and-middle-income countries (LMICs), it failed to garner the necessary support of high-income countries (HICs), who largely adopted protectionist stances specific to IP law and nationalistic stances where essential supplies were concerned, enacting a series of export bans (Tegama 2020). This, importantly, makes apparent the politicisation of health-related supply chains in a way that allows us to problematise the intersection of international legal provisions and coloniality in global health. It also enables us to trouble what we mean by empowerment and participation in, for example, South Africa's cases where the country and its population and indeed the populations of its global south counterparts seem to operate at a disadvantage that has implications for access to healthcare and early deaths at population level.

In the case of the recent mpox outbreak, which at present has two distinct clades, known as clade I and clade II, both of which have subclades, Ia and Ib and IIa and IIb. Clade I has long been endemic in Central and parts of Western Africa, historically spreading amongst populations with close contact to animals. Mpox did not become an international public health concern, nor a designated global health priority for endemic geographies until it started affecting people in Europe and the United States following an outbreak of clade IIb, a less severe clade that spread beyond the endemic zone and across 116 countries primarily through sexual networks in 2022. As a response, there was a shift in mpox guidelines, and HICs moved to vaccinate at-risk populations, then stockpiled vaccines in a context where they could have been supplied to endemic zones that typically have the more severe clade Ib that has a higher mortality rate. By September 2023, the Democratic Republic of Congo (DRC), had seen the first of what would become many cases over the course of the year, such that by August 2024, the mpox outbreak was declared a public health emergency by the Africa Centre

for Disease Control (Africa CDC) and the World Health Organisation (WHO) in a context where HICs had largely continued to stockpile vaccines since 2022 (cf. Gostin et al. 2024). Centring the epidemiology of and response to mpox importantly highlights the colonial present within our global health systems that do not value all lives in the same way. Mpox is a case amongst many systemic failures along historically colonial fault lines that translate into systemic inattention to some diseases. This is in part because the setting of priorities occurs outside and without the participation of those who come from affected communities. This has implications in terms of early deaths and avoidable morbidity. Thus, creating a fair and equal playing field in health requires us to tussle with the legacy of colonialism across our global health systems, both at the governance level and within organisations.

3 Dismantling structures premised on coloniality

We introduce the concepts of delinking, de-legitimising and de-barriering within global health to fracture the colonial project and critically look at global health to create paths towards fair and equal playing fields in health.

3.1 Delinking

We borrow from Samir Amin (cf. 1987; 1990) and anti/de-colonial scholars (cf. Hountondji 1990; Wallerstein 1997; Mignolo 2004) who have built on and expanded his concepts that are concerned with describing (Eurocentricism), understanding (extraversion) and addressing (delinking) the colonial question and "the permanence of the reproduction of the centre/periphery imbalance" (Amin 1990, 7). Where Amin's analyses focused on economics, we find use for his concepts within the broader decolonial space. For example, *Eurocentrism* describes the colonial legacy in global health. Broadly speaking, Eurocentrism describes a worldview of Europe as the centre of the world, less so cartographically, but rather as a cultural expression that articulates the worldview of Western Europe and North America as the primary drivers of progress and development and as the custodians of reason and authority on universal values (cf. Wallerstein 1997; Sundberg 2009). To illustrate the notion

of Eurocentrism in global health, we crudely use *Global Health 5050's* (2020) work on power, privilege, and priorities across 200 of the most prominent global health organisations. The data on power/privilege asymmetries analysed in the context of historical and geographical lines grafts onto colonial history. On a crude level, geographically, we find 85% of headquarters of global health organisations in Europe and North America, with two-thirds located in Switzerland, UK and USA and 80% of their leaders coming from HICs, 50% being from the UK and the US, in a context where only 5% of leaders are women from LMICs. These data highlight historical power imbalances, Eurocentrism and a lack of representation, equality and diversity in spaces that hold decision-making power. We argue these and extraversion to be key factors in the overall misalignment between health priorities and the burden of disease across LMICs.

Extraversion can be understood as a system that is externally oriented. Hountondji (cf. 1990) applied the term to knowledge, describing extraversion as the denial and marginalisation of local knowledge and the creation of a system where the function of knowledge in former colonies would be to respond to the demands of external, former colonial powers. We see forms of extraversion in global health: for example, in priority setting and resource allocation such as in the context of the comparatively heavier investment in infectious disease to the lack of resources dedicated to addressing non-communicable disease (NCDs), despite their comprising a larger disease burden. This underscores that "global health is firmly centered on those with power and privilege, and focused on their generosity and saviorism" (Pai 2022) rather than the needs and knowledge on the ground. This speaks to the need to decolonise and restructure global health's ecosystem, including delinking LMIC national health priorities from the imperatives of the global north and towards the needs of local populations, not as a move towards autarky-popularized today by extreme right-wing movements in HICs, but rather a deliberate choice to subvert colonial logic and the imposition of ill-suited universalisms.

Delinking can be employed to empower local actors to organise health-related content, including priority setting and metrics of success in line with locally relevant epistemologies, by placing emphasis on LMIC actors for not only participating but leading in research and policy relevant to their communities. In this way delinking can be viewed as a firm commitment to including previously marginalised

voices in global health, particularly in the context of developing health priorities including shared priorities between countries and across regions. Additionally, delinking can contribute to decolonising global health's intersecting disciplines, such as international relations, ethics and economics by revaluing and reasserting the epistemological density of the global majority. Moving toward polycentricism (Amin, 1990) and pluriversal knowledge structures can change the terms of reference for conceptualising health, ethics or the politics that govern global health institutions and the economic models that run along historically colonial lines to the detriment of the health of those on the raw end of supply chains. For example, if we centre the DRC's cobalt mining communities, which are home to two thirds of the world's known cobalt deposits and fuel a multi-billion-dollar industry on which modern technologies are reliant and our *collective* green revolution is predicated on, we may hypothesise conceptualisations of health in those communities. We may, for example, consider the challenges faced by expectant mothers within the region who are reported to have the highest metal concentrations reported in pregnant women, and increased risk of foetal abnormalities that are associated with "paternal occupational mining exposure" and inadequate personal protective equipment (PPE) (Brusselen et al. 2020, 166). Brusselen and colleagues (2020) assert environmental metal exposure to be a global health concern, and we contend that in the context of a non-extraverted health system in the DRC this would be a global health concern and a health priority for mining communities.

An attentive and nuanced analysis of this specific case study would have implications for not just health but ethics, law, human rights and the economics of just and equitable transitions in energy. Participation of local populations in global health therefore has implications for how we articulate health and the linkages between health, social and economic dimensions, and developing de-siloed, multidisciplinary indicators that can facilitate meeting health for all. In this way, delinking has epistemic implications. Mignolo (cf. 2007) conceptualises this as epistemic delinking, which has the potential to decentre the current manifestations of power and privilege to distribute governing and decision-making power to local communities and non-traditional actors who have been absent in setting health for their own communities. To this end, we introduce the notion of subsidiarity as a necessary condition for participation in section 4.

3.2 De-legitimising

Some longstanding practices and structures that undergird global health thinking and praxis were created during colonial times and continue to operate on those premises. Since these practices have acquired formal or tacit legitimacy as the *normal*, there is a need for de-legitimisation as a two-prong process that requires action on the part of the formerly colonised and coloniser. De-legitimisation entails challenging and where necessary abolishing practices and structures that continue to entrench coloniality. Speaking during the 2024 United Nations General Assembly about the need to change existing structures in order to rise up to the challenges of climate change, Barbados' Prime Minster Mia Amor Mottley said,

> "my friends, we will not succeed in overcoming our existential challenges if we are not prepared to change the global governance structures that are rooted in the outcome of World War II (WWII), and have become unsuited in today's world […] this approach to governance reinforces that it is acceptable to have first and second class citizens […] the tentacles of power remain almost as it was a century ago […] what the world needs now is a reset" (PMOBarbados 2024).

With the end of WWII also came the establishment of the international development industry, inextricably linked to an attempt to maintaining influence and control in former colonies on issues that would endanger the West in the face of waning colonial empires such that "the project of ending poverty [would be left] in place of the project of colonialism" (Burgess 2023, 5) and would have a great bearing on sectors such as health in the *developing world*.

Delegitimisation is in this way concerned with the creation of more ethically viable governing structures, laws and institutions, whether in terms of restructuring TRIPS, or seriously addressing the challenge of representation across organisations, within board composition and in research, funding, authorship and editorial power (cf. Pai 2022). Delegitimisation requires problematising the current structure and making unacceptable continued systemic failures that result in diminished health outcomes for historically colonised communities. This in part requires previously colonised people to agitate for their rights, to not have their populations treated like second class citizens and to resist decisions about their health and the health priorities of their communities being made

outside their territories and without the participation of the local communities. There is therefore a necessity for both the previously colonised and colonisers to co-construct new governing structures. This requires historically colonial countries to engage in self-scrutiny and do away with barriers to participation that legitimise structural inequality. Delegitimisation entails forms of abolitionism understood as doing away with practices that are harmful.

3.3 De-barriering

Creating pathways towards equal and level playing fields in global health will require examining the historical origins of existent barriers to participation to consider whether barriers that exclude certain groups remain congruent with our decolonial aspirations and moral positioning on structural inequality in global health. Given that colonisation is a subtraction of agency, we find participation to be a necessary condition for decolonisation. We associate it with a distribution of power with an emphasis on political will, representation and the voices of local communities in developing "concepts, visions, and experiences linked to the health-disease-care process" (Furtado et al., 2022, 4086). There is therefore a need to develop ways of working, thinking and being that can facilitate multiplicity in health/disease perspectives and epistemic diversity in conceptualisations of health to include epistemologies of the global south and non-hegemonic conceptions of disease, health, care and the accompanying determinants of health across different communities. The biomedical system erects barriers that exclude different forms of knowing specific to, for example, indigenous populations who have been practicing medicine within their communities for centuries (cf. Cloatre 2019). The totality of the western, biomedical-based system of healthcare is bolstered by a barrage of legal tools that render other ways of knowing illegal, which is a form epistemicide. It is a deliberate creation of a knowledge empire that seeks to exclude rather than to understand. We therefore contend that our job as global health practitioners is to consider whether the systems we have set up and the systems we are operating within cause harm and effectuate a form of violence towards others. This includes, for example, examining nomenclature to consider what constitutes as *alternative medicine* and what is it deemed an alternative to and how

the presumed standard evolved into the standard. A participatory global health system would prioritise finding points of convergence and building a diverse body of knowledge on different conceptions of what it means to be well, what contributes to wellness, rather than building a model that penalises other ways of knowing. From this viewpoint, subsidiarity is a necessary condition of participation both in theory and praxis because it embraces elements of agency and non-abandonment and it speaks directly to the colonial question and the subtraction of agency. It creates room for decentralisation and greater levels of participation and empowers local communities as decision-makers (cf. de Campos-Rudinsky et al. 2024).

4 Pathways towards rebuilding a more equitable global health space

In the previous section we focused on the structures that require dismantling to discontinue coloniality. In this section, we suggest broad pathways towards building a decolonised global health space.

4.1 Subsidiarity

Global health involves multiple actors that typically intersect, working across multiple levels, including state actors within and across states, non-state actors, organisations and local units. A sufficient conceptualisation of participation in global health would therefore need to consider what participation looks like across all of those levels, incorporating theoretical aspects of participation such as democracy, power and representation with practical aspects of how participatory processes can be effected across varying levels and within institutions to incorporate perspectives of and prioritise the collective will of citizens in communities who will be affected at the point of health policy implementation (cf. Furtado et al. 2022). The global health arena at large is marked by structural inequality that broadly mirrors a society that still runs along colonial lines and with an accompanying global economic system, institutions and laws. The principle of subsidiarity offers a way of promoting agency that empowers local actors in matters pertaining to their health.

Subsidiarity has its origins in classical philosophy. It was adopted by Catholic social thinking as an organising principle and has been instituted into the Western legal frameworks of the European Union (cf. Benson 2022). At its core, it is a structural principle of justice (cf. de Campos-Rudinsky 2024, 1200) concerned with the locus of decision-making power in contexts where self-governing lower-level authorities such as civil associations and regional or local authorities exist alongside higher authorities like the state. The principle upholds the basis of the association between higher and lower authorities should as helping lower authorities help themselves (cf. Finnis 2016, 133), this principle. By choosing commitments "including commitments to friendship and other forms of association" (Finnis 2016, 133) which can be realised through projects that may have a shared purpose and require concerted efforts with the higher authorities that the lower group has chosen to associate with.

The primary concern of subsidiarity is that lower authorities should not be usurped by higher authorities even in circumstances where the lower authority lacks efficiency that the higher authority would be able to provide if it usurped the lower authority. We find these two notions of subsidiarity useful in the context of global health; the idea of agency means that even the choice to associate lies with the lower authority. This is relevant for example for *donor* states and organisations and the question of whether they were chosen by local populations or simply assumed the role based on the idea that they could more efficiently address health needs. De Campos-Rudinsky and colleagues (2024, 1200) contend that subsidiarity is "comprised of two essential elements – non-abandonment and agency", citing a balance between the two as crucial to justice, with overreach across either likely to lead to either an undermining of the agency of local populations or protectionist/nationalistic stances that will be detrimental to collaborative approaches and collective action. Importantly, the element of agency is associated with plurality and epistemic freedom – the empowerment of local actors and revaluing of their ways of thinking and knowing, including within the scope of priority setting and the subsequent primacy of that knowledge in policy and decision-making processes (cf. ibid).

4.2 A three-pronged approach to decolonization

Without sufficiently engaging with the question of participation in a way that incorporates the principle of subsidiarity, the global health arena remains at risk of entrenching the harms of coloniality. We propose a framework for addressing coloniality within global health. The tool we propose is imagined as a deliberative dialogue instrument to acknowledge positive achievements and to discuss specific actions that higher-authority organisation (state and non-state actors) can take. The tool focuses on the three spheres of hegemony/power, abolitionism, and commitmentalism.

Hegemony/Power examines and deals with issues of control, disempowerment and dependency. In thinking about hegemony, we are invited to examine issues of power and empowerment, with the goal of achieving a more equitable distribution among stakeholders, especially those whose power has been subtracted through colonialism. If addressed thoroughly, this can contribute to the notion of delegitimised unjust power. The *abolitionist* approach is about asking what attitudes, actions and positionalities which entrench coloniality ought to be discontinued. We often think of change as a matter of doing something. Abolitionism invites us to think about change in a different way, that is, discontinuing what is detrimental to the pursuit of desired ends. Addressed thoroughly, this can contribute to the *de-barriering* routes to participation within global health. Finally, *commitmentalism* means making a conscious effort to go beyond the status quo to foster the ends desired. This may require going out of our comfort zone to engage with new stakeholders and ideas and to some extent making ourselves more vulnerable and accountable to a wider range of audiences. This process, done properly, contributes to delinking from the imperatives of the centre, including in priority setting and opting to relink in new, epistemically just ways.

Below, we provide a non-exhaustive illustration of how the tool can be used by global health institutions to trigger a process of reflection that can lead to change. This form of change can be incremental and gradual with measurable objectives.

Hegemony/Power	Abolitionism	Commitmentalism
What knowledge, whose knowledge, whose voices are included in the academic and research programmes? How is credit for academic output attributed (publication)?	What concepts inherited that speak to colonialism and white supremacy (language, terms like *tropical medicine, third world, capacity building*) should we drop? What forms of epistemic violence are we practicing that need to be curbed?	What knowledge and which voices should we actively seek to include in our programmes? What types of uncomfortable inclusion and sharing of knowledge are we willing to accommodate? What forms of inclusion can we factor into our academic outputs to ensure equity in recognizing the contributions of less powerful persons and groups?
How does the business model of our institution feed into systems that reduce populations in the periphery to working and serving the centres of power? How green are our spaces, working and traveling habits? What sort of accountability towards the populations we want to serve in Global Health is included in our praxis?	When was the last time we reviewed and discontinued/modified relationships with our partnerships, suppliers, etc. through a lens that promotes greater equity and ecological awareness?	What policies can we adopt to avert our work from feeding into models that impoverish peoples and communities that have historically been marginalized?
Who holds power in our organization? How is this linked to morally insignificant (biological) categories?	Which groups of people does our system of selection (staff and students) systematically exclude, and how can we stop that?	How can we actively ensure that marginalized persons (gender, race, religion) are included not only numerically but meaningfully in our spaces?

5 Concluding Remarks

Global health emerged and operates within a world that has largely been shaped by colonial histories. Paying attention to the harms that this backdrop against which global health programmes and initiatives are realised is important if we want to build a more equitable world that is free from the crippling legacies of colonialism.

One way to take seriously the challenge of decolonisation is to understand the problem and to address it with both a *pars destruens* that is critical of existing structures and praxis, but also to embark on a *pars construens* that envisages a different world and global health space.

The *pars destruens,* delinking, de-legitimising and de-barriering are tasks that generate different duties to those who continue to enjoy the ill-accrued benefits of colonialism and those who continue to suffer its ills. Large part of the task lies on the former to self-examine attitudes, institutions and praxis and to embrace the discomfort that change might bring. The *pars construens,* subsidiarity, hegemonic redistribution, abolitionism and commitmentalism are shared tasks that require working towards shared measurable goals, albeit from different standpoints. The tip of the balance here lies more on those who have suffered the ills of colonialism to actively seek a different world, keeping in mind the rhetorical question of caution Fanon asks in the concluding lines of his famous work, *Black Skin, White Masks*: "Was my freedom not given to me to build a world of you?".

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