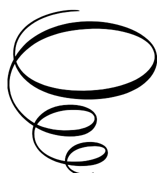
Decolonial Gestures in Global Health

Decolonial Gestures in Global Health

Edited by

Gerald M. Boodoo

Cambridge Scholars Publishing



Decolonial Gestures in Global Health

Edited by Gerald M. Boodoo

This book first published 2026

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Copyright © 2026 by Gerald M. Boodoo and contributors

All rights for this book reserved. No part of this book may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior permission of the copyright owner.

ISBN: 978-1-0364-6784-5
ISBN (Ebook): 978-1-0364-6785-2

CONTENTS

Chapter 1 1
Coloniality and Global Health
Gerald M. Boodoo

Chapter 2 24
Decolonizing Global Health Ethics Principles
Peter Ikechukwu Osuji, C.S.Sp.

Chapter 3 42
Decolonizing the Study Abroad Experience in Global Health
Adrian Wright-FitzGerald

Chapter 4 67
Decolonizing Approaches to Communicable Diseases
Bridget Calhoun

Chapter 5 99
Decolonizing Western Medical Knowledge and Practice: Engaging Indigenous Healers and Healing
Lisa López Levers

Chapter 6 147
Toward Sustainable Initiatives in Childhood Injury
Kelly Gettig

Chapter 7 211
Creating Decolonial Practice: Caring for Immigrants and Refugees
Khlood Salman and Brianna Clark

Chapter 8 236
Language and Decolonial Practice in Healthcare
Panayiota Senekkis-Florent and Aigerim Aliakparova

Chapter 9 264
Legacies of Colonialism in Speech-Language Pathology
Megan Overby and Panayiota Sennekis-Florent

Chapter 10 311
Decolonization Resilience
Faina Linkov, Zinat Abdrakhamanova, and Aizhan Raushanova

Chapter 11 332
Street Medicine: A Decolonial Option
James S. Withers, MD FACP

Chapter 12 359
Community Gardens as a Decolonial Option: Sourcing Food Equitably
Plaxedes Chitiyo

Chapter 13 403
Creating Equitable Water Access in South Africa
David M. Kahler and Joshua N. Edokpayi

Chapter 14 415
Necessity of Growth: Accepting the Gifts of Failure
Vibhuti Arya

Bibliography 434

Contributors 519

CHAPTER 1

COLONIALITY AND GLOBAL HEALTH

GERALD M. BOODOO

This chapter introduces the concepts of coloniality and decoloniality and relates them to global health. It provides the broad theoretical framework to which the contributions in this volume are responses from multiple locations, professions, and viewpoints. As such, it gives a brief overview of decolonial thought then presents how such thinking can address the coloniality constitutive of global health. Finally, it gives an overview of the contributions to this volume.

I. Brief Overview of Decolonial Thought

Over the past two decades and more, some scholars have been filling in the gap in Latin American Studies on the colonial history of the region. Their point of contention is that when one thinks of modern colonialism, one easily refers to Africa, Asia, and the Caribbean, but not so easily to the Americas and specifically Latin America.[1] As these scholars began to investigate this submerged reality, they discovered structural patterns of thinking and acting that appeared to be present in what they called the modern project—the expansion of selective European ways of thinking and acting designed to consolidate European hegemony. The structures they uncovered and the mode of thinking they have promoted are now termed coloniality and decolonial thinking. This volume makes four main points regarding decolonial thinking: 1.) modernity situates all people in relation to itself, with some populations "inside" and others "outside"; 2.) coloniality, as an aspect of modernity, centers Euro-American thought and otherizes

[1] See Mabel Morana, Enrique Dussel, and Carlos Jauregui, eds., *Coloniality at Large: Latin America and the Postcolonial Debate*, (Durham, NC: Duke University Press, 2008); Walter D. Mignolo and Catherine Walsh, *On Decoloniality: Concepts, Analytics, Praxis* (Durham, NC: Duke University Press, 2018).

everything else; 3.) decolonial knowledge production requires a new method delinked from coloniality, rather than simply being knowledge production *against* coloniality; and 4.) decolonial thinking will be imperfect because all our lives and systems have been steeped in coloniality for centuries—none of us is immune.

First, we need to understand that modernity has created a world system that for the first time in the history of the world has linked all (or virtually all) parts of the world and subsumed them into a connected system. Along with this comes the realization that not everyone and everywhere has benefited from these connections. There is a dark side to this modern system of coloniality so that there are those who benefit from the modern project, those who are "inside" modernity and wield the power of modernity, who can too easily be blinded to the millions who are negatively affected by modernity, who are "outside." This "outside" of modernity is termed the "colonial difference." By colonial difference is meant "the place and experiences of those who have been the object of inferiorization on the part of others who, in the midst of the colonial endeavor, have come to consider themselves to be superior. It is a place and experience constituted as an exteriority to modernity according to a negative logic (a logic of inferiorization)."[2]

Second, there is a "coloniality of power" that privileges and enshrines Euro-American thinking by constituting itself in (i) the classification and reclassification of the planet population, especially along racial, civilizational, and evolutionary lines (the concept of culture becomes crucial in this task); (ii) institutional structures which function to articulate and manage such classifications (state, university, church, etc.); (iii) the definition of spaces appropriate to such goals; and (iv) an epistemological perspective that articulates, legitimates, and channels its production of knowledge.[3] Walter Mignolo explains that "Eurocentrism becomes, therefore, a metaphor to describe the coloniality of power from the perspective of subalternity. From the epistemological perspective, European local knowledge and histories have been projected to global designs."[4]

---

[2] Gregory A. Banazak and Luis Reyes Ceja, "The Challenge and Promise of Decolonial Thought to Biblical Interpretation," *Postscripts* 4, no. 1 (2008): 116.
[3] Cf. Anibal Quijano, "Coloniality of Power, Eurocentrism, and Social Classification", in *Coloniality at Large: Latin America and the Postcolonial Debate*, ed. Mabel Morana, Enrique Dussel, Carlos A. Jauregui (Durham, NC: Duke University Press 2008), 181-224.
[4] Walter D. Mignolo, *Local Histories/Global Designs: Coloniality, Subaltern Knowledges, and Border Thinking* (Princeton, NJ: Princeton University Press, 2000), 17.

Third, decolonial thought seeks to produce knowledge formed from the colonial difference. What is needed is a new way of thinking, not new ideas. As such, if one speaks from the perspective of the colonial difference, one also speaks from what Mignolo calls the "colonial wound," and therefore decolonial thought and practice does privilege knowledge from these spaces of oppression, the victims of modernity, but with the realization that even though it is produced from "outside" modernity it still is linked to the modern project. The colonial wound is created by coloniality. So decolonial thought gives rise to an ethics and a politics of pluriversality. Standing in opposition to global and totalitarian designs created in the name of universality (which usually means a particularity claiming to be universal), pluriversality is an attempt to make visible and viable a multiplicity of knowledges, forms of being, and visions of the world. "Pluriversality is equality-in-difference, the possibility that many worlds can fit in one world. It is the future alternative to modernity/coloniality."[5] Decolonial thinkers see this as occurring across many disciplines and many facets of life, hence they assert the "transdisciplinary" and "transcultural" nature of decolonial thinking. This mixture of perspectives works to unmask the "purity" of disciplines and the so-called "universality" of modernity.

Fourth, though decolonial thinking speaks about the "inside" and "outside" of modernity, these are markers designed to explain the colonial difference and colonial wound. They are not to imply that there is a point of view that stands outside of the modern project looking in. In fact, decolonial thinking insists that it is impossible to have a vantage point from which one can view the goings on of the modern project, there is no *epoche* as early phenomenologists would say. This means that we all understand the workings of coloniality by already experiencing it and partaking in neocolonial bounty as a postcolonial or anticolonial human agent. Franz Hinkelammert refers to this as the "privileged exploited," and Gayatri Spivak calls this "neocolonizing anticolonialism."[6] In other words, in working to decolonize, we must be aware of our complicity and use of colonial methodologies, languages, and epistemic locations and the trap of substitutive ideology. This might be the most important aspect of decolonial thinking, since it does not set itself up as the answer to the problems of

---

[5] Banazak and Ceja, "The Challenge and Promise," 118.

[6] Cf. Franz J. Hinkelammert, "Changes in the Relationships between Third World Countries and First World Countries," in *Spirituality of the Third World: A Cry for Life*, ed. K.C. Abraham and Bernadette Mbuy-Beya, (Maryknoll, NY: Orbis Books, 1994), 9-19; Gayatri Spivak, *A Critique of Postcolonial Reason: Toward a History of the Vanishing Present* (Cambridge: Harvard University Press, 1999), 191.

modernity but as a way of de-linking accustomed relationships with a view to re-linking in multiple, relative, and admittedly impure ways.

Finally, we want to clarify that decolonial thought is different from postmodern and postcolonial thinking. The postmodern debate, as its name suggests, still is a debate situated in the heart of modernity, attempting to rekindle enlightenment principles in non-dogmatic or non-overarching narrative form. Despite this, it still holds to the core belief that the European enlightenment is the measure by which one determines preference for food, culture, language, music, business, and education. It is still heavily inscribed with the coloniality of power, and for all its intentions is unable to seriously address the colonial wound and the millions of people affected by it. Decolonial thought rejects the idea that discourse generated from the inside of modernity can effectively address the colonial difference. Postcolonial thought, though similar to decolonial thought, tends to be, again as the name implies, critical thinking in response to the aftermath of colonialism in previously colonized nations after "independence." Such thinking is uniformly anti-colonial and focuses on issues of identity, politics, and social construction in postcolonial contexts. Its aim is to forge reasoned trajectories for members of postcolonial societies as they navigate post-independence/globalization phenomena with the hope of creating stable, secure, productive, and locally owned/managed contexts. While this constructive activity is important for decolonial thought, its seeming implication that there is an epistemic location outside of the colonial matrix of power from which it can be critiqued as a space to create alternatives, is rejected by decolonial thought. Indeed, for decolonial thought, one must make the clear distinction between colonialism and coloniality—the former a period of occupation, and the latter the epistemic structures that remain long after the period of occupied colonialism has ended.

II. Decolonial Thought and Global Health

Attempts to push back against the colonial matrix of power, as Quijano calls it, are now receiving a lot more attention in various disciplines, especially since the publication in 1999 of Linda Tuhiwal Smith's *Decolonizing Methodologies: Research and Indigenous Peoples*, which led to a lot of "decolonizing sociology" texts and shifts in ethnographic research as well as in scientific methodology (which still has a long way to go). It is now commonplace to find decolonial publications in sociology, philosophy, geography (especially cultural and anarchist geography), psychology, theology, environmental studies, economics, etc.

In terms of global health, Emory has an ongoing virtual speaker/panel series on *Decolonizing Global Health*; Harvard had a student conference of the same name in 2021 on the same topic; Jones and Bartlett publishers hosted a webinar in Fall 2022 that give this area special mention; and the Consortium of Universities for Global Health (CUGH) had as a subtheme for their annual meeting in Spring 2023 *Decolonizing-Reforming Global Health, Equity, Justice, Global Health Education and Research* and constituted a working group on decolonization that has published findings from a survey of global health practitioners.[7] The publications of *Reimagining Global Health* in 2013 by Farmer et al., editors, and *Decolonizing Global Mental Health*, also in 2013 by China Mills, made earlier impacts in this area as well and set the stage for greater awareness of this topic.[8] So clearly, it is an area with increasing interest and involvement, and there are increasing publications in the area as well as greater networking, such as with the American Academy of Pediatrics GHEARD (Global Health Education for Equity, Anti-Racism and Decolonization) initiative.[9] We must also mention the creation of the University of Global Health Equity launched in 2015 in Rwanda that has been attempting to reimagine health care from these perspectives with varied success.[10]

A. Its Genesis

Global health as a discipline was generated out of colonial tropical medicine, which was primarily designed to treat the disease burden of colonizers in contact with colonial contexts they either inhabited as settler colonies or worked in for a period of time.[11] This means that the very focus

---

[7] Madelon L Finkel et al., "What Do Global Health Practitioners Think about Decolonizing Global Health?", *Annals of Global Health* 88, no. 1 (July 27, 2022): 61, https://doi.org/10.5334/aogh.3714.

[8] Paul Farmer et al., *Reimagining Global Health: An Introduction* (Berkeley: University of California Press, 2013); China Mills, *Decolonizing Global Mental Health: The Psychiatrization of the Majority World* (New York: Routledge, 2014).

[9] American Academy of Pediatrics, *GHEARD: Global Health Education for Equity, Anti-Racism, and Decolonization*, https://www.aap.org/GHEARD-Global-Health-Education-for-Equity-Anti-Racism-and-Decolonization?srsltid=AfmBOooZjEjg2fx29s7OvAQ2z4IWyt57PuK5SQVJrcaYmaBL1elHek0l

[10] University of Global Health Equity, https://ughe.org.

[11] Maysoon Hussain et al., "Colonization and Decolonization of Global Health: Which Way Forward?", *Global Health Action* 16 (2023): 2186575,

of global health, as an inheritor of colonial health care, has never been the local and Indigenous communities in the colonies and former colonies in which it was immersed. If anything, these local communities were, and have been, deliberately mistreated, to further the physical, mental, economic, and military designs of colonizers and former colonizers and those of their "home" countries, the colonial centers of power. Instances of the non-consensual and deleterious use of local and Indigenous populations for experimental medical use is well documented and underscores the colonial dispensation that disregards and discards people and ideas that are deemed to be on the "outside" of modernity.[12]

Features of the result of this colonial inheritance in current global health include the power imbalance in funding priorities and "partnerships"

---

https://doi.org/10.1080/16549716.2023.2186575; Xiaoxiao Kwete, "Decolonizing Global Health: What Should Be the Target of This Movement and Where Does It Lead Us?", *Global Health Research and Policy* 7 (December 2022): 3, https://doi.org/10.1186/s41256-022-00237-3; Abraar Khan, "Opinion: It's Time to End The Colonial Mindset In Global Health", *NPR* December 30, 2019, https://www.npr.org/sections/goatsandsoda/2019/12/30/784392315/opinion-its-time-to-end-the-colonial-mindset-in-global-health; Eugene T. Richardson, "On the Coloniality of Global Public Health," *Medicine Anthropology Theory* 6, no. 4 (December 2019): 101–118, https://doi.org/10.17157/mat.6.4.761; Delivette Castor and Luisa N. Borrell, "The Cognitive Dissonance Discourse of Evolving Terminology from Colonial Medicine to Global Health and Inaction Towards Equity," *Preventive Medicine* 163 (October 2022): 107227, https://doi.org/10.1016/j.ypmed.2022.107227; Sara Seims, Narmeen Hamid, and Hayley Lynn Herzog, "Shifting the Power: A Road Map to Decolonize Global Health," https://amplifychange.org/wp-content/uploads/2023/03/Shifting-the-Power-A-Road-Map-to-Decolonize-Global-Health-Feb-2023.pdf; David McCoy et al., "Developing an Agenda for the Decolonization of Global Health," *Bulletin of World Health Organization* 102 (2024): 130-136, https://doi.org/10.2471/BLT.23.289949.

[12] L L Wall, "The Medical Ethics of Dr. J Marion Sims: A Fresh Look at the Historical Record," *Journal of Medical Ethics* 32, no. 6 (2006): 346-350, https://doi.org/10.1136/jme.2005.012559; Susan M. Reverby, "Ethical Failures and History Lessons: The U.S. Public Health Service Research Studies in Tuskegee and Guatemala," *Public Health Reviews* 34 (2012): 13, https://doi.org/10.1007/BF03391665; Andrew R. Marks, "Doctors from Hell: The Horrific Account of Nazi Experiments on Humans," *The Journal of Clinical Investigation* 116, no. 1 (January 2006): 2, https://doi.org/10.1172/JCI27539; University of Adelaide, "Apology for Past Experiments on Aboriginal People," February 8, 2002, https://www.adelaide.edu.au/news/news314.html; "Report: Britain Tested Chemical Weapons on Indian Colonial Troops," *Voice of America*, November 1, 2009, https://www.voanews.com/a/a-13-2007-09-02-voa11/338520. html, among many, many others.

that still echo colonial interests; the continued portrayal of journals, studies, and voices from HICs and colonial centers of power as more scientifically and contextually relevant and superior; the scapegoating of vulnerable populations; the inability to relinquish leadership roles to local and Indigenous personnel; the colonial mindset HIC participants uncritically bring to their endeavors; the deemphasis in professional training on the wider historical and social contexts that create and maintain the health inequities present under the guise of "objectively" treating patients; and political-economic models that promote cure over a concerned focus on prevention. This is obviously not an exhaustive list, but it conveys the heavy lifting that needs to be done in the attempts at decolonizing global health. In addition, as decolonial theorists insist, and as mentioned earlier, one cannot expect meaningful solutions to the problems created by the "inside" of modernity *from* the "inside" of modernity, since it is clear that colonial centers of power are primarily concerned about their own survival and health. So where do we start? How about looking at how practitioners in the field view this issue.

B. Reflexivity

Members of a working group of CUGH, in conducting a quantitative and qualitative study published in 2022, did a survey of CUGH members engaged in global research as well as of members of the African Forum for Research and Education in Health (AFREhealth).[13] "The overwhelming majority of respondents strongly agreed (59%) or agreed (32%) with the statement: "Colonialism adversely impacts global partnerships." Among those from HICs, two-thirds (62.5%) strongly agreed and one-quarter (25%) agreed. Among those from LMICs, half (52.9%) strongly agreed with the statement while 41.2% agreed. The findings indicate that those in HICs, compared to LMICs, feel more strongly that colonialism adversely impacts global partnerships.[14]

Other quantitative findings show that 65.6% of the respondents have experienced the negative effects of colonialism in their global partnerships and 58% of the respondents felt that they do not have equal control over research studies, with 50% of those from HICs disagreeing compared to 59% of those from LMICs agreeing. In terms of perceptions about not being viewed as equal partners we see the discrepancy between HIC and LMIC practitioners, with with 29.2% agreeing with this perception and 54.2% disagreeing from HICs and with 58.9% agreeing with this

[13] Finkel et al., "What Do Global Health Practitioners Think."
[14] Finkel et al., "What Do Global Health Practitioners Think."

perception and 23.5% disagreeing from LMICs, almost in inverse proportion. In terms of qualitative findings,

> the main theme from the LMIC respondents was that financial interests control the power in the relationship and that funders have their own agendas and enter partnerships with preconceived viewpoints. In addition, respondents felt that greater value is often attached to skill sets of HIC partners, with little if any value attached to the skill sets of LMIC partners, unless they were educated in HICs."[15]

In response to what could make things better, especially for LMIC partners, the qualitative responses highlighted trust, respect, transparent decision making, and equitable financial allocations and opportunities. The authors highlighted three main areas of concern to be addressed. The first is fair distribution of authorship, the second is an over-representation of White men from HICs in global health leadership postions and the listing of collaborators from LMICs as co-principal investigators, and the third is that research is driven by the interests of HICs in which funding agencies are mainly based.[16]

The study reconfirms the patterns of colonialty that are present in global heath practice and practitioners, with a clear sense that even when HIC partners are aware of coloniality, it proves difficult to shed the White supremacy mindset and White savior complex in global health, as well as to equitably share leadership and resources.[17]

In another study published in 2023 looking at efforts to decolonize global health curricula by interviewing study coordinators and faculty of global health programs involved in crafting these programs, researchers indicated that participants weren't really sure how to go about decolonizing

---

[15] Finkel et al., "What Do Global Health Practitioners Think."

[16] R. *Zachariah* et al., "Applying the ICMJE Authorship Criteria to Operational Research in Low-Income Countries: The Need to Engage Programme Managers and Policy Makers," *Tropical Medicine and International Health* 18, no. 8 (August 2013): 1025-*1028,* https://doi.org/10.1111/tmi.12133. Cited in Finkel et al., "What Do Global Health Practitioners Think about Decolonizing Global Health?".

[17] Agnes Binagwaho, Brianna Ngarambe, and Kedest Mathewos, "Eliminating the White Supremacy Mindset from Global Health Education," *Annals of Global Health* 88, no. 1 (2022): 32, https://doi.org/10.5334/aogh.3578.; Anup Agarwal et al., "The White Savior Industrial Complex in Global Health," *BMJ Global Health Bolgs*, March 11, 2020, https://blogs.bmj.com/bmjgh/2020/03/11/the-white-savior-industrial-complex-in-global-health/; Emmanuel Bua and Saad Liaqat Sahi, "Decolonizing the Decolonization Movement in Global Health: A Perspective from Global Surgery," *Frontiers in Education* 7 (2022): 1033797, https://doi.org/10.3389/feduc.2022.1033797.

their programs and fell back on diversity, equity, and inclusion initiatives to frame their understandings.[18] Key in this study is its identification of institutional barriers, such as lack of institutional support and funding for changes, rules and regulations related to accreditation, and the role funders and multilateral organizations need to play in decolonization efforts. Another key point is the blending of decolonial efforts with DEI initiatives. While there is intersectionality in these areas, they are not quite the same, and clarity regarding the difference and the strategic needs of one differing from the other is needed.[19]

These studies highlight the gap in understanding the issue between HIC and LMIC colleagues as well as the significant epistemological, structural, and institutional barriers that need to be addressed.

C. Main Issues and Perceived Resolutions

While not a hard distinction, one can view the main problems of coloniality in global health under the interconnected yet distinct areas of systems/structures and epistemology. They need go hand in hand: one cannot change minds only to consistently confront sluggish or intractable systems, and vice versa. Creating structural change without the mindset to implement it appropriately is like leading a parade with no one following.

D. Systems, Structures

On the structural level, an overarching problem in global health is its attachment to the political economy of neoliberal capitalism.[20] Of course, this is also linked to the funding priorities of HICs and the medical industrial complex associated with them, as well as the power dynamics at play in setting priorities and funding avenues for global health. While attention has been drawn in this volume to coloniality in global health, one should also recognize the continuing colonization of global health itself and how it is still being used to colonize, as an intrinsic part of the political economy of modernity. We must not lose sight of the fact that medicine and public

---

[18] Kalbarczyk A, Perkins S, Robinson SN and Ahmed MK, "Decolonizing global health curriculum: from fad to foundation", *Frontiers in Education,* 2023, 8:1217756, doi: 10.3389/feduc.2023.1217756.

[19] DEI initiatives tend to work within existing structures to improve equity and inclusiveness *in those structures* whereas decolonial thought works to transform and fundamentally change structures inherited from colonialism and perpetuated by coloniality.

[20] McCoy et al., "Developing an Agenda."

health have always been determined by social, political, and economic values, as was made very clear during the COVID-19 pandemic.

In "Decolonizing Global Health," Xiaoxiao Kwete et al. suggest that systemic reforms that target fundamental assumptions of global health need to take place.[21] In thinking of solutions, they mention colonial vestiges in daily practices which question what constitutes success in global health, organizational and regulatory practices that beg the question of equity in representation, and the need for a paradigm shift in terms of for whom and where solutions can be found. They also emphasize that decolonizing global health will not succeed *without decolonizing our global political economies*. On this latter point, David McCoy et al. bemoan the fact that public-private partnerships and private financial actors have increasing influence over global health and call for a restoration of the authority and capacity of intergovernmental organizations, especially WHO, so that there is less private influence and greater international networking.[22] These authors also point out, in reference to the COVID-19 pandemic, that as a trillion dollar economic sector, the power of pharmaceutical companies supported by a corporate friendly system can result in massive profits for these companies while simultaneously leaving millions of people in financially destitute situations.[23]As the political economy of neoliberal capitalism pushes more and more deregulation, there is the need to "engage with reforms of the political economy aimed at tackling: the under-regulated financialization of the health sector; the abuse of intellectual property rights; the control of key sectors in the health domain by a few oligopolistic corporations; and the high levels of tax avoidance that enable and perpetuate wealth extraction and inequality."[24] These power imbalances of the political economy are also entrenched in the structures of educational institutions and continue to inform how collaboration and partnerships in global health are shaped. In "Decolonising Global Health Research: Shifting Power for Transformative Change,"[25] Ramya Kumar et al. target this issue by asking three interrelated questions: who leads, who controls, and who benefits in global health research? The unequivocal answer to all these questions are HICs or the Global North (GN), who also determine the neoliberal economic agenda. After looking at multiple suggestions on how to rectify the situation, the

---

[21] Kwete et al., "Decolonizing Global Health."
[22] McCoy et al., "Developing an Agenda," 133.
[23] McCoy et al., "Developing an Agenda," 133.
[24] McCoy et al., "Developing an Agenda," 133.
[25] Ramya Kumar, Rajat Khosla, and David McCoy, "Decolonising Global Health Research: Shifting Power for Transformative Change," *PLOS Global Public Health* 4, no. 4 (April 2024): e0003141, https://doi.org/10.1371/journal.pgph.0003141.

authors comment that the guidelines offered by most of the article cited above suggested solutions that "neglect the wider contextual factors that shape agenda-setting in global health research as well as the actors and institutions that control and benefit from them." In response to this, they list seven points that they think can allow for a structural shifting of the balance of power:

- Decolonize global health education through a critical examination of the epistemological and ideological bases of global health,
- Establish a system to track grant funding flows and patterns at the global level,
- Develop and implement international guidelines for research funders, research institutions, and academic publishers,
- Strengthen national research capacity through domestic investments in research,
- Build consensus for a global (public) fund for health research,
- Strengthen existing mechanisms to prevent brain drain from the Global South,
- And revamp intellectual property rights regimes to promote fairness.

These suggestions attempt to foster equity-oriented research approaches based in local ownership and emphasize that profit-driven incentives, economically, intellectually, and ideologically, do not serve equity in global health partnerships and health care. Of course, though global health is concerned about improving health and health equity for all people, a population's health depends very much on the local disease burdens, social determinants, and other localized factors that influence it. In that sense, all health is local, even if it is affected by global forces. Similarly, structural change must have mutual and meaningful engagement with local communities for there to be lasting change that decolonizes current approaches. In "A Pragmatic Approach to Equitable Global Health Partnerships in Academic Health Sciences," James A. Amisi et al. outline five key principles that can help to accomplish this, all aimed at acknowledging "the complex history of inequities both locally and globally that have existed since before the modern field of global health first began to emerge" and working to deconstruct them.[26] The principles are solidarity; shared accountability; sustainability and capacity-building; humility,

[26] James A. Amisi et al., "A Pragmatic Approach to Equitable Global Health Partnerships in Academic Health Sciences," *BMJ Global Health* 8 (2023): e011522, https://doi.org/10.1136/bmjgh-2022-011522.

cultural sensitivity, and mutual respect; and compliance with applicable laws, ethical standards, and codes of conduct. All five principles seek to engage local contexts with mutual respect and equitable considerations, and correctly consider how this may differ in culturally differing contexts. This begs the question, how do we then adjust mindsets to a decolonial way of thinking?

E. Epistemology

In her TED Talk "The Danger of a Single Story," Nigerian writer and thinker Chimamanda Adichie, in speaking on the power that narratives have to shape our perceptions and understandings, mentions that if you begin a narrative "secondly," for example with the rebellion against colonial authorities, instead of "firstly," with the violent invasion by the colonial power, then you have a very different understanding of the context.[27] This holds true for global health as well. Speak "secondly" of the lack of resources and qualified personnel in formerly colonized LMICs but not "firstly" of the colonial systems put in place in those contexts to exploit and drain resources and personnel, and one gets a very different perception and approach to those contexts and its people.

In an interesting article on how individuals in the Democratic Republic of the Congo were perceived to view the Ebola virus during the 2018 Ebola outbreak, Eugene T. Richardson mentions how a Harvard School of Public Health study, which concluded that people refused to seek formal medical care or accept vaccines because they did not believe Ebola as a virus was real, became a cultural norm of understanding among global health practitioners in the area.[28] Robinson objects to the easy equation of lack of trust being equivalent to non-compliant actors without some understanding of the social and medical history of the context. Without this broader framework of understanding, questioning why there is hesitancy and mistrust among the population towards the vaccine and other treatment, Robinson claims that health care providers are doing symbolic violence to the population and are in fact co-responsible fabricants of narratives that maintain coloniality and the colonial matrix of power. Not only is the unjust gathering of facts an issue, but the choice of variables used in modeling is also problematic. Again, who controls and shapes the narrative creates the

---

[27] Chimamanda Ngozi Adichie, "The Danger of a Single Story," *TEDGlobal*, July 2009, https://www.ted.com/talks/chimamanda_ngozi_adichie_the_danger_of_a_single_story.

[28] Richardson, "On the Coloniality of Global Public Health."

"fact," so Robinson calls for counter-hegemonic narratives and practices that can decolonize our global public health perceptions and practices.

Coupled with this is the logic of inferiorization of the knowledge and skills of those trained and practicing in non-HIC settings, as well as of traditional and Indigenous ways of healing and practice.[29] Appeals to scientific authority, usually located in the HICs, is projected as universal, while it is clear that so-called "evidence-based" decisions are being driven by international political concerns. Indeed, "global health governance is not solely driven by epistemic consensus among experts in global health but depends on the degree of overlap or alignment with hegemonic economic and security interests."[30] We must foster counter-hegemonic ideas and practices in global health that delink us from the colonial matrix of power and its logic of inferiorization. In addition, it is a well recognized problem that medical practitioners in HICs tend to inappropriately treat minority groups and see them as non-compliant if, as providers, they cannot relate to their patient's context. Racism and sexism still play a role in the inequities in health care, and this has been a deliberate consequence of the colonial matrix of power.[31] Dismantling White supremacy and gender bias remain abiding tasks in decolonizing global health, and in this age of the Anthropocene, we have to attend to how the prevailing "cure over prevention" emphasis in neoliberal health care, which generates medical waste and requires ever larger medical facilities, affects the environment.[32]

---

[29] Alexandros Kentikelenis, Leonard Seabrooke, and Ole Jacob Sending, "Global Health Expertise in the Shadow of Hegemony," *Studies in Comparative International Development* 58 (2023): 347-368, https://doi.org/10.1007/s12116-023-09405-z; Castor and Borrell, "The Cognitive Dissonance Discourse."

[30] Kentikelenis, Seabrooke, and Sending, "Global Health Expertise," 353.

[31] Mathieu Rees, "Racism in Healthcare: What You Need to Know," *Medical News Today*, October 18, 2024, https://www.medicalnewstoday.com/articles/racism-in-healthcare; Ruqaiijah Yearby, Brietta Clark, and José F. Figueroa, "Structural Racism in Historical and Modern US Health Care Policy," *Health Affairs* 41, no. 2 (February 2022), https://doi.org/10.1377/hlthaff.2021.01466; see articles in the *British Medical Journal* 2025 Special Issue *2025 Racism in Medicine: Are We Making Any Progress?*, https://www.bmj.com/racism-in-medicine; see also the British Medical Association, "Sexism in Medicine Report," June 28, 2024, https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/gender-equality-in-medicine/sexism-in-medicine-report; Mignolo and Walsh, *On Decoloniality*, chapter 7.

[32] Shanthi Van Zeebroek, "The Environmental Impact of Medical Waste," *Earth.org,* Global Commons, July 22, 2022, https://earth.org/medical-waste-disposal/; Edyta Janik-Karpinska et al., "Healthcare Waste—A Serious Problem for Global Health," *Healthcare* (Basel) 11, no. 2 (2023): 242,

In addition, though we live in a world filled with multiple languages and cultures, they tend to be seen as challenges to be overcome because of the predominance of colonial languages and cultural norms in the curricula, training, and practice in global health. Rather than being valued as resource opportunities to expand the evidentiary bases of what passes for wellness and illness, they are portrayed as obstacles to learning and development and thereby reinscribe the colonizing effect of global health on differing local cultures and their languages. This also applies in how we relate to traditional and Indigenous forms of diagnosis and treatment, applying the logic of inferiority to denigrate non-Western medical practices.

In summary, recognizing the systemic, structural, and epistemological colonial vestiges in global health allows us to propose ways to delink from them and then relink to epistemologies, structures, and practices that prioritize pluriversal and equitable solutions.

III. Pluriversal Gestures

This work presents a number of decolonial gestures for health care providers and educators. We use the word "gesture" as a way to link thought, planning, activity, and performance.[33] It attempts to convey the notion that these thoughts and actions are important yet minimal beginnings in the wider movement of decolonizing global health. It also recognizes the massive colonial structures that global health currently inhabits and is cognizant of the need to create cracks in those structures as a way to open wider avenues for constructive reimaginations of global health.

The contributors to this volume, with some exceptions, co-teach courses on global health and in general have not recognized themselves as being consciously involved in decolonizing global health. As a result, they represent the vast majority of professionals in global health who, once aware of coloniality and the hold it has on global health, are willing to find ways in their respective sectors to delink from it and relink to decolonial epistemologies and practices. In this sense, this volume both represents and is meant for the range of people involved in global health. In addition, while

---

https://doi.org/10.3390/healthcare11020242; Yujun Wei et al., "Environmental Challenges from the Increasing Medical Waste Since SARS Outbreak," *Journal of Cleaner Production* 291, no. 1 (April 2021): 125246, https://doi.org/10.1016/j.jclepro.2020.125246.

[33] Walter D. Mignolo, "Looking for the Meaning of 'Decolonial Gesture,'" Hemisperic Institute, https://hemisphericinstitute.org/en/emisferica-11-1-decolonial-gesture/11-1-essays/looking-for-the-meaning-of-decolonial-gesture.html.

the text is in English, this volume attempts to offer pluriversal perspectives from various areas in the health professions and care and from contributors with roots in various places: Kazakhstan, South Africa, Zimbabwe, Iraq, India, Ukraine, Trinidad & Tobago, Cyprus, and the USA. Throughout the chapters in this volume you will see appeals to cultural sensitivity and competence, the call for equitable solutions to problems, and the need for respect and dignity when relating to others, but you will also see great diversity in the understandings and approaches to decolonizing global health.

In *Decolonizing Global Health Ethics Principles*, Peter Osuji, C.S.Sp., critically examines power dynamics within global health ethics in order to eliminate the supremacy ideology of coloniality and HICs. He emphasizes the need to reevaluate curricula, research selection, design, publication, access to research outcomes, and partnerships in global health ethics. His proposed methods for decolonization include cultivating transformative learning, centering Indigenous and marginalized voices, pedagogic discomfort, incorporating decolonial pedagogies, and rethinking curriculum content. In general, Osuji urges a shift in epistemic power and in the determination and interpretation of how global health ethics principles are created, shaped, and applied. He emphasizes pluriversality and equity as the lenses through which these principles must be crafted and understood to allow for the ongoing realization of a decolonial health ethics.

Decolonizing the Study Abroad Experience in Global Health, by Adrian Wright-Fitzgerald, presents a programmatic outline for study abroad programs in a critical framework that counters voluntourism and fosters ethical, equitable, and sustainable international educational experiences. It emphasizes cultural humility and the centering of local voices by prioritizing the perspectives and needs of host communities, in order to promote mutual respect and learning and to cultivate global citizens committed to justice and equity. An important part of this process for Wright-Fitzgerald is finding ways to help students embed in their target culture and avoid unintentional damage through projects that don't suit the needs of the local population or through projects that are abandoned after students leave. She sees decolonizing the study abroad experience as a crucial step towards creating ethical, equitable, and impactful educational experiences for students.

In *Decolonizing Approaches to Communicable Diseases*, Bridget Calhoun discusses coloniality in the treatment of infectious diseases, which often manifests in exploitative research that primarily benefits high-income areas and in top-down solutions that apply Western medicine without accounting for context. Encouraging the study of bio-politics in the training of global health professionals, she argues that the direct correlations between

biological functions and the ideologies of those in power helps to describe what is taking place in context. Context is key in treating infectious diseases in postcolonial settings, where culture, community, living situations, and social expectations may be different from what providers assume. For example, she describes HIV prevention messaging as not accounting adequately for the fact that condom use is low in some countries because children are considered a great blessing. She recommends paying close attention to culture as treatment and prevention strategies are developed.

Decolonizing Western Medical Knowledge and Practice: Engaging Indigenous Healers and Healing, by Lisa López Levers, discusses the value of honoring Indigenous and Traditional medicine in Africa and not pushing it aside in favor of Western medicine. Championing ethnorehabilitation, "an eco-systemic, praxeological construct which acknowledges the comprehensive nature of persons with disabilities through functional relationship to their respective cultures and in person/community-appropriate interaction with their environments and psycho-ecological pluralism," Levers wants to break down attitudinal barriers in biomedical school curricula.[34] Adding psycho-ecological pluralism to this mix, Levers stresses that engaging with local medical practitioners, both Western biomedical and Indigenous, should be a major aim of all international health care endeavors.

Kelly Gettig, in *Toward Sustainable Initiatives in Childhood Injury*, argues that children are a vulnerable population with an increased risk of injury due to physiological and developmental factors, and those living in poverty are disproportionately impacted. Indeed, children are the most vulnerable of the vulnerable, and the dangers they face are compounded in countries with a history of being colonized. Children in these areas suffer disproportionally from head trauma caused by abuse and from injuries sustained in road accidents, the latter because living conditions are often extremely dense and colonial infrastructure was not designed with the local population in mind. On top of this, our collective belief in children's lack of agency over themselves is itself a form of coloniality and needs to be addressed by giving children participatory roles in developing child safety public policy. Gettig gives an impressive and extensive list of pediatric trauma as well as a list of organizations and inititatives she thinks are creating sustainable initiatives in childhood injury. Though she sees these intitiatives and partnerships as positively furthering work in this area, she is aware that structural solutions coming from the inside of modernity are problematic but thinks that these initiatives are at least countering the

[34] See page 120.

hegemony of colonial frameworks and creating possibilities for decolonial practice.

An area that is very relevant to our contemporary social and political climate is our approach to immigrants and refugees. Khlood Salman and Brianna Clark, in *Creating Decolonial Practice: Caring for Immigrants and Refugees*, write of the particular health challenges suffered by refugees. They argue that refugees by their nature are in danger of serious health problems, including not just an interruption of care for chronic diseases but also new conditions that develop from the stress of dislocation and relocation. Their problems are compounded by social difficulties in their new countries, such as a lack of understanding of the health care system, language barriers, and inadequate housing and employment. Salman and Clark suggest that refugees themselves are an underutilized asset in care for their own community, as they understand the background culture and are experiencing many of the same issues. In caring for immigrants and refugees, we enter into a decolonial practice of health care that forces us to realize the wider context of health care, the partiality of our professional knowledge, and the need for trusting relationships.

Language and Decolonial Practice in Health Care, by Panayiota Senekkis-Florent and Aigerim Aliakparova, extends the discussion of the previous chapter by focusing on language barriers in the treatment of refugees. In an ever-changing global landscape that has resulted in increasing cultural and linguistic diversity, they argue that insufficient interpretation services present a significant barrier to care for refugees that hospitals and providers often attempt to address in an ad hoc manner, such as through the use of children who might be present in the room. Effective communication, especially language, plays a significant role in enhancing equitable and patient-centered health outcomes. Therefore hospitals should prioritize professional interpretation services that do not depend on patients' family members, and governments should note refugees' potential for providing professional interpretation services and cultural consults as they become accustomed to their new home. The authors contend that equitable language access is decolonial practice since language has been used as a colonial tool for dominance and erasure of Indigenous and local knowledge systems. It also serves to foreground culturally responsive health care teams.

Megan Overby and Panayiota Sennekis-Florent, in *Legacies of Colonialism in Speech-Langauge Pathology*, discuss the widespread nature of coloniality throughout the discipline of speech language pathology, with roots in settler colonialism, which often determines "pathologies" on the basis of how far a person's speech falls from the White professional standard. A further dimension of coloniality is the lack of adequate speech

language pathology access in remote, poor, and predominantly Black or Indigenous areas. Overby and Sennekis-Florent argue that a better approach to speech pathology is to attract practitioners from culturally and linguistically diverse backgrounds, particularly ones who were raised in the culture where they live and work and have bi/multilingual capacities. Transforming speech language pathology training and practice by engaging decolonial theory will help to further this process.

Decolonization Resilience, by Faina Linkov, Zinat Abdrakhmanova, and Aizhan Raushanova, addresses the colonial problem that health infrastructure and health focus/services were originally determined by the economic, social, and political requirements of colonial rulers rather than by the health needs of the local population. They argue that infrastructural resilience is key in successful health care transitions from colonial to postcolonial systems, and that keeping and repurposing practical components of the colonial systems can serve as a foundation for building better and more resilient postcolonial systems. They see positive examples of this in Rwanda and Cuba with systems that center community leadership, nurture cultural identity and knowledge, build diverse coalitions, develop economic independence, and build adaptive capacity. While repurposing colonial infrastructure has ideological undertones, they recognize, as decolonial theorists do, that one doesn't have alternatives outside of modernity to work with and that repurposing, as a new way of thinking, can be a decolonial option.

James Withers discusses *Street Medicine: A Decolonial Option*. As a movement that aims to counter the structural violence of health care systems, it aspires to a health care model in which "going to the people" might lead to empowerment and justice for those who have been excluded and oppressed. This is a powerful grassroots movement that uses solidarity and accompaniment as decolonial practice. The streets become the classroom and training locations for health care providers, and health care goals arise out of the relationships formed with those living on the streets, subverting the tradional dynamic of health care and its delivery. Wherever street medicine is practiced, it becomes a countercultural act of resistance to the incentives and patterns of existing health care and to the neoliberal economic model it inhabits. People and their dignity come first.

In *Community Gardens as a Decolonial Option: Sourcing Food Equitably*, Plaxedes Chitiyo promotes "community gardening as one of the key grassroots level strategies that can be used to address food inequity at both local and global scales by challenging colonial and capitalist ideologies that have created a dominant industrialized food system characterized by

disparities in food access."[35] For Chitiyo, this regenerative form of agriculture is an immediately accessible decolonial solution to food insecurity, where families can raise the plants that are familiar to them and where they do not have to worry about affordability. These gardens also promote food sovereignty whereby communites can determine what, when, and how to plant and resurface Indigenous agricutural practices that have been submerged by colonial systems. As a realistic and immediate solution, community gardens offer a tangible and practical healthy decolonial option to the dominant colonial industrialized food system.

David Kahler and Joshua Edokpavi in *Creating Equitable Water Access in South Africa* present a highly specific argument on water access in South Africa that has wide implications for other areas and issues. They argue that coloniality is not just an interpersonal or social matter that can be educated away, rather, it includes infrastructure itself, in how cities were built to prioritize or oppress certain populations. Their essay traces water access in the Bantustan, the area to which Black individuals were forcibly relocated under apartheid and where many of them continue to live. In the Bantustans, water facilities often do not work due to lack of maintenance, which means inadequate or no access to water. Other examples, such as in Johannesburg, where water meters do not allow sufficient water through the tap in certain neighborhoods, indicate the proximal problem of infrastructure in equitable water access. Kahler and Edokpavi argue that updating infrastructure to adequately reach all households is a key aspect of decoloniality.

In *Necessity of Growth: Accepting the Gifts of Failure*, Vibhuti Arya offers an exercise in decolonial praxis to empower the reader to self-reflection and actualization of their power for agency. Even well-intentioned practitioners and educators will often fail their patients and students due to the widespread nature of coloniality in social interactions, as shown in her example of a dental student whose residency was filled with roadblocks created by educators expecting them to behave in a certain way. Arya writes that practitioners and educators should not shy away from negative feedback about their implicit biases, because this feedback will help them grow and change. "It is crucial for us to apply a critical lens to our work, both personally and professionally, so that we may bring all of ourselves to this work and invite others in the same accountable manner."[36] The structure of the self also needs decolonizing.

This volume would not have been completed without the work of Gwendolen Jackson, who kindly arranged this text for publication. I also

[35] See page 359.
[36] See page 431.

have to thank the contributors to this volume who, though unsure of exactly what it meant to decolonize global health, jumped into the fray with inquisitive minds and came out with emerging realizations of their own decolonial gestures in their respective areas. I applaud their courage and openness to learning. Our hope is that this volume offers opportunites for others to also engage in gestures that decolonize the training, thinking, and implementation of global health.

Bibliography

Adichie, Chimamanda Ngozi. "The Danger of a Single Story." *TEDGlobal*, July 2009. https://www.ted.com/talks/chimamanda_ngozi_adichie_the_danger_of_a_single_story.

Agarwal, Anup, Nadra Crawford, Viet Nguyen, and Andrea Walker. "The White Savior Industrial Complex in Global Health." *BMJ Global Health Bolgs*, March 11, 2020. https://blogs.bmj.com/bmjgh/2020/03/11/the-white-savior-industrial-complex-in-global-health/.

American Academy of Pediatrics. *GHEARD: Global Health Education for Equity, Anti-Racism, and Decolonization*. https://www.aap.org/GHEARD-Global-Health-Education-for-Equity-Anti-Racism-and-Decolonization?srsltid=AfmBOooZjEjg2fx29s7OvAQ2z4IWyt57PuK5SQVJrcaYmaBL1elHek0l

Amisi, James A., María Sofía Cuba-Fuentes, Esther M. Johnston, Martha Makwero, Shailendra Prasad, Tasleem Ras, Daria Szkwarko, and Klaus von Pressentin. "A Pragmatic Approach to Equitable Global Health Partnerships in Academic Health Sciences." *BMJ Global Health* 8 (2023): e011522. https://doi.org/10.1136/bmjgh-2022-011522.

Andrew R. Marks. "Doctors from Hell: The Horrific Account of Nazi Experiments on Humans." *The Journal of Clinical Investigation* 116, no. 1 (January 2006): 2. https://doi.org/10.1172/JCI27539.

Banazak, Gregory A., and Luis Reyes Ceja. "The Challenge and Promise of Decolonial Thought to Biblical Interpretation." *Postscripts* 4, no. 1 (2008): 113-127. https://doi.org/10.1558/post.v4i1.113.

Binagwaho, Agnes, Brianna Ngarambe, and Kedest Mathewos. "Eliminating the White Supremacy Mindset from Global Health Education." *Annals of Global Health* 88, no. 1 (2022): 32. https://doi.org/10.5334/aogh.3578.

British Medical Association. "Sexism in Medicine Report." June 28, 2024. https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/gender-equality-in-medicine/sexism-in-medicine-report.

Bua, Emmanuel, and Saad Liaqat Sahi. "Decolonizing the Decolonization Movement in Global Health: A Perspective from Global Surgery." *Frontiers in Education* 7 (2022): 1033797. https://doi.org/10.3389/feduc.2022.1033797.

Castor, Delivette, and Luisa N. Borrell. "The Cognitive Dissonance Discourse of Evolving Terminology from Colonial Medicine to Global Health and Inaction Towards Equity." *Preventive Medicine* 163 (October 2022): 107227. https://doi.org/10.1016/j.ypmed.2022.107227.

David McCoy, Anuj Kapilashrami, Ramya Kumar, Emma Rhulea, and Rajat Khosla. "Developing an Agenda for the Decolonization of Global Health." *Bull World Health Organ* 102 (2024): 130-136. https://doi.org/10.2471/BLT.23.289949.

Farmer, Paul, Jim Yong Kim, Arthur Kleinman, and Matthew Basilico. *Reimagining Global health: An Introduction*. Berkeley: University of California Press, 2013.

Finkel Madelon L., Marleen Temmermann, Fatiman Suleman, Michele Barry, Melissa Salm, Agnes Bingawaho, and Peter H. Kilmarx. "What Do Global Health Practitioners Think about Decolonizing Global Health?", *Annals of Global Health*, 2022 Jul 27;88(1):61. https://doi.org/10.5334/aogh.3714.

Hinkelammert, Franz J. "Changes in the Relationships between Third World Countries and First World Countries." In *Spirituality of the Third World: A Cry for Life*, edited by K.C. Abraham and Bernadette Mbuy-Beya, 9-19. Maryknoll, NY: Orbis Books, 1994.

Hussain, Maysoon, Mitra Sadigh, Majid Sadigh, Asghar Rastegar, and Nelson Sewankambo. "Colonization and Decolonization of Global Health: Which Way Forward?" *Global Health Action* 16 (2023): 2186575. https://doi.org/10.1080/16549716.2023.2186575;

Janik-Karpinska, Edyta, Rachele Brancaleoni, Marcin Niemcewicz, Wiktor Wojtas, Maurizio Foco, Marcin Podogrocki, and Michal Bijak. "Healthcare Waste—A Serious Problem for Global Health." *Healthcare* (Basel) 11, no. 2 (2023): 242. https://doi.org/10.3390/healthcare11020242.

Kalbarczyk, Anna, Sylvie Perkins, Sabreena N. Robinson, and Mahnoor K. Ahmed. "Decolonizing Global Health Curriculum: From Fad to Foundation." *Frontiers in Education* 8 (2023): 1217756. https://doi.org/10.3389/feduc.2023.1217756.

Kentikelenis, Alexandros, Leonard Seabrooke, and Ole Jacob Sending. "Global Health Expertise in the Shadow of Hegemony." *Studies in Comparative International Development* 58 (2023): 347-368. https://doi.org/10.1007/s12116-023-09405-z.

Khan, Abraar. “Opinion: It’s Time to End The Colonial Mindset In Global Health.” *NPR,* December 30, 2019. https://www.npr.org/sections/goatsandsoda/2019/12/30/784392315/opinion-its-time-to-end-the-colonial-mindset-in-global-health.

Kumar, Ramya, Rajat Khosla, and David McCoy. “Decolonising Global Health Research: Shifting Power for Transformative Change.” *PLOS Global Public Health* 4, no. 4 (April 2024): e0003141. https://doi.org/10.1371/journal.pgph.0003141.

Kwete, Xiaoxiao, Kun Tang, Lucy Chen, Ran Ren, Qi Chen, Zhenru Wu, Yi Cai, and Hao Li. “Decolonizing Global Health: What Should Be the Target of This Movement and Where Does It Lead Us?” *Global Health Research and Policy* 7 (2022): 3. https://doi.org/10.1186/s41256-022-00237-3.

Mignolo, Walter D. “Looking for the Meaning of ‘Decolonial Gesture.’” Hemisperic Institute. https://hemisphericinstitute.org/en/emisferica-11-1-decolonial-gesture/11-1-essays/looking-for-the-meaning-of-decolonial-gesture.html.

Mignolo, Walter D. *Local Histories/Global Designs: Coloniality, Subaltern Knowledges, and Border Thinking.* Princeton, NJ: Princeton University Press, 2000.

Mignolo, Walter D., and Catherine Walsh. *On Decoloniality: Concepts, Analytics, Praxis*. Durham, NC: Duke University Press, 2018.

Mills, China. *Decolonizing Global Mental Health: The Psychiatrization of the Majority World*. New York: Routledge, 2014.

Morana, Mabel, Enrique Dussel, and Carlos Jauregui, eds. *Coloniality at Large: Latin America and the Postcolonial Debate*. Durham, NC: Duke University Press, 2008.

Quijano, Anibal. “Coloniality of Power, Eurocentrism, and Social Classification.” In *Coloniality at Large: Latin America and the Postcolonial Debate*, edited by Mabel Morana, Enrique Dussel, and Carlos A. Jauregui, 181-224. Durham, NC: Duke University Press 2008.

Rees, Mathieu. “Racism in Healthcare: What You Need to Know.” *Medical News Today*, October 18, 2024. https://www.medicalnewstoday.com/articles/racism-in-healthcare.

“Report: Britain Tested Chemical Weapons on Indian Colonial Troops.” *Voice of America,* November 1, 2009. https://www.voanews.com/a/a-13-2007-09-02-voa11/338520.html.

Reverby, Susan M. “Ethical Failures and History Lessons: The U.S. Public Health Service Research Studies in Tuskegee and Guatemala.” *Public Health Reviews* 34 (2012): 13. https://doi.org/10.1007/BF03391665;

Richardson, Eugene T. "On the Coloniality of Global Public Health." *Medicine Anthropology Theory* 6, no. 4 (December 2019): 101–118. https://doi.org/10.17157/mat.6.4.761.

Seims, Sara, Narmeen Hamid, and Hayley Lynn Herzog. "Shifting the Power: A Road Map to Decolonize Global Health." https://amplifychange.org/wp-content/uploads/2023/03/Shifting-the-Power-A-Road-Map-to-Decolonize-Global-Health-Feb-2023.pdf.

Spivak, Gayatri. *A Critique of Postcolonial Reason: Toward a History of the Vanishing Present*. Cambridge: Harvard University Press, 1999.

University of Adelaide. "Apology for Past Experiments on Aboriginal People." February 8, 2002. https://www.adelaide.edu.au/news/news314.html.

University of Global Health Equity. https://ughe.org.

Van Zeebroek, Shanthi. "The Environmental Impact of Medical Waste." *Earth.org*, Global Commons, July 22, 2022. https://earth.org/medical-waste-disposal/.

Wall, L L. "The Medical Ethics of Dr. J Marion Sims: A Fresh Look at the Historical Record." *Journal of Medical Ethics* 32, no. 6 (2006): 346-350. https://doi.org/10.1136/jme.2005.012559.

Wei, Yujun, Meng Cui, Zhonghua Ye, and Qingjun Guo. "Environmental Challenges from the Increasing Medical Waste Since SARS Outbreak." *Journal of Cleaner Production* 291, no. 1 (April 2021): 125246. https://doi.org/10.1016/j.jclepro.2020.125246.

Yearby, Ruqaiijah, Brietta Clark, and José F. Figueroa. "Structural Racism in Historical and Modern US Health Care Policy." *Health Affairs* 41, no. 2 (February 2022). https://doi.org/10.1377/hlthaff.2021.01466.

Zachariah, R, T. Reid, R.Van den Bergh, A. Dahmane, R. J. Kosgei, S. G. Hinderaker, K. Tayler-Smith, M. Manzi, W. Kizito, M. Khogali, A. M. V. Kumar, B. Baruani, A. Bishinga, A. M. Kilale, M. Nqobili, G. Patten, A. Sobry, E. Cheti, A. Nakanwagi, D. A. Enarson, M. E. Edginton, R. Upshur, and A. D. Harries. "Applying the ICMJE Authorship Criteria to Operational Research in Low-Income Countries: The Need to Engage Programme Managers and Policy Makers." *Tropical Medicine and International Health* 18, no. 8 (August 2013): 1025-1028. https://doi.org/10.1111/tmi.12133.

CHAPTER 2

DECOLONIZING GLOBAL HEALTH ETHICS PRINCIPLES

PETER IKECHUKWU OSUJI, C.S.SP.

I. Introduction

Colonization significantly impacted various aspects of life in the colonies, including religion, medicine, education, the economy, politics, and power, morality, and knowledge systems. Even though different countries previously under the colonial system are now independent, some colonial practices and attitudes persist subtly and continue to influence life today in the former colonies. People are beginning to recognize how knowledge generated in the colonizing countries, which are also high-income countries (HICs), defines practices and informs thinking that aids in the development or the detriment of knowledge systems in the former colonized or low- and middle-income countries (LMICs). This is evident in medical or global health, global health ethics, and, therefore, in global health ethics education. The awareness of this detriment has engineered decoloniality, the call for the decolonization of most disciplines, including global health ethics. In this paper, I will describe briefly the roots or origins of decoloniality from the Enlightenment to modernity and colonization. Then I will explore decoloniality's resounding call to address the impacts and evils of coloniality and colonial thoughts. Some practical examples and solutions will be offered, followed by a brief conclusion.

An added reason why this research is important is that one of the foundational moral values of global health ethics is social justice. As we know, social justice has the following three basic parts: a) addressing the health needs of the disadvantaged or marginalized, b) "combatting epistemic injustice by paying particular attention to the experiences and perspectives of those whose voices have been marginalized, silenced, devalued, and inferiorized," and c) promoting their involvement in decision-