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Uchechukwu Ngwaba
Lincoln Alexander School of Law, Toronto Metropolitan University

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TAKING 'THIRD WORLD' LIVES SERIOUSLY: DECOLONISING GLOBAL HEALTH GOVERNANCE TO PROMOTE HEALTH CAPABILITIES IN THE GLOBAL SOUTH

UCHECHUKWU NGWABA*

Abstract

Behind glib claims of universalism in global health, evidenced by the push for universal health coverage in the Sustainable Development Goals 2030 (SDGs), lies an uncomfortable truth about the unequal, uneven and broken system of the existing framework for global health governance. A situation made more evident by the behaviour of powerful states of the Global North at the height of the Covid-19 pandemic through the hoarding of vaccines, refusal to accommodate waivers to the Trade-Related Aspects of Intellectual Property Rights (TRIPS) regime to allow cheaper versions of the Covid-19 vaccines to be manufactured for the Global South and the preference for securitisation over solidarity in the response to the pandemic. The rhetoric of "vaccine apartheid" was deployed by WHO Director General to describe this lack of solidarity by Global North States (particularly in the context of vaccines procurement). However, this paper argues contrarily that the colonial foundations of the current framework for global health governance, which does not take Third World lives as seriously as those of citizens of the West, has functioned exactly as designed. This has led to the "othering" of Third World peoples, generating pathologies of suffering and vulnerabilities in their encounter with global health governance frameworks. Informed by critical Third World Approaches to International Law (TWAIL) this paper makes the case for decolonising existing frameworks for global health governance to promote health capabilities in the Global South.

I. INTRODUCTION

Perhaps a good place to begin this paper is to acknowledge that the framework for global health governance is broken, not functioning *as designed*,[1] and there is yet no agreement on a fix. The problem does not lie with lack of effort to fix the broken system, but an inability by States of the Global North and South[2] to align positions on priority areas in the redesign of the framework. Commitments to so-called principles of 'solidarity'[3] and 'universalism'[4] in advancing health coverage so that no one is left behind[5] now ring hollow given the undisguised lack of solidarity in the international response to the Covid-19 pandemic. A response that was characterised by self-serving acquisition of critical lifesaving vaccines,[6] hoarding of vaccines,[7] and an initial refusal by key Global North States to accommodate requests tabled at the WTO

***** Assistant Professor, Lincoln Alexander School of Law, Toronto Metropolitan University, Canada; LLB, BL, LLM, DipLaw, PhD; uche.ngwaba@gmail.com.

[1] Perhaps it is functioning as it was originally intended to function – a point I aim to interrogate deeply in this paper.

[2] The categorisation "Global South" (or in earlier terminology, the Third World, or geographically Asia, Africa, Latin America and the Pacific) is rooted in international development studies. On the basis of a North-South binary, inequalities between 'developed' and 'developing' countries have been given prominence. See Willy Brandt, *North-South: A Programme for Survival – The Report of the Independent Commission on International Development Issues Under the Chairmanship of Willy Brandt* (Cambridge, MA: MIT Press, 1980); see also Rory Horner, "Towards a New Paradigm of Global Development" (2020) 44:3 Progress in Human Geography 415 at 417.

[3] A growing realisation of the universalisation of the threats posed by diseases has motivated wealthy countries to expand their solidarity groups – that is community of persons with whom they feel similarity. See Peter G N West-Oram & Alena Buyx, "Global Health Solidarity" (2017) 10:2 Public Health Ethics 212 at 214.

[4] A first glance, the field of Global (Public) Health connote a universality of humanity and interests. Yet, as Afffun-Adegbulu and Adegbulu rightly observe, "the hierarchisation of humanity is very much an issue in Global (Public) Health. See Clara Affun-Adegbulu & Opemiposi Adegbulu, "Decolonising Global (Public) Health: From Western Universalism to Global Pluriversalities" (2020) 5 BMJ Global Health 1 at 1.

[5] SDG Target 3.8 aims to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all – see World Health Organization, "The Global Health Observatory" (30 June 2022) online: <who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/sdg-target-3.8-achieve-universal-health-coverage-(uhc)-including-financial-risk-protection>; universal health coverage involves a set of health goals adopted by member states of WHO in 2005 to be achieved by health systems around the world (*Sustainable Health Financing, Universal Coverage and Social Health Insurance*, WHA, 9th Plen Mtg, UN Doc A58/20 (2005)). These goals call upon member states to secure a level of access to healthcare for their population that is not catastrophic and impoverishing. Health spending is said to be "catastrophic" whenever it is 40% or more of the capacity to pay (see Kei Kawabata, Ke Xu, & Guy Carrin, "Preventing Improverishment through Protection against Catastrophic Health Expenditure", (2002) 80:8 Bulletin World Health Organization 612; see also Uchechukwu Ngwaba, "A Right to Universal Health Coverage in Resource-Constrained Nations? Towards a Blueprint for Better Health Outcomes" (2018) 5 Transnational Human Rights Review 1.

[6] Megan Twohey, Keith Collins & Katie Thomas, "With First Dibs on Vaccines, Rich Countries Have 'Cleared the Shelves'" (December 15, 2020), online: <nytimes.com/2020/12/15/us/coronavirus-vaccine-doses-reserved.html?smid=tw-share>; Seye Abimbola et al, "Addressing Power Asymmetries in Global Health: Imperatives in the Wake of the Covid-19 Pandemic" (2021) 18:4 PLoS Medicine 1 at 2.

[7] "UN Confirms Hoarding of Covid Vaccines by 10 Developed Countries" (17 February 2021) (Miami, Wire Feed, ProQuest One Business); Hoda Kotb et al, "The New COVID Concern Vaccine Hoarding" (22 January 2021) (New York, CQ Roll Call); Daphne Psaledakis, "Developing Nations' Plea to World's Wealthy at U.N.: Stop Vaccine Hoarding," Reuters (22 September 2021), online: <reuters.com/world/developing-nations-plea-worlds-wealthy-un-stop-vaccine-hoarding-2021-09-22/>.

by India and South Africa for waivers to the Trade-Related Aspects of Intellectual Property Rights (TRIPS) to enable:

> [a]n effective response to COVID-19… through …rapid access to affordable medical products including diagnostic kits, medical masks, other personal protective equipment and ventilators, as well as vaccines and medicines for the prevention and treatment of patients in dire need.[8]

Even though progress has been made in negotiating terms of a waiver,[9] it has come at significant costs to many Global South States.[10] The consequence is that in the pandemic recovery efforts, two different realities have emerged for the Global North and the Global South.[11]

Concerned by lack of solidarity by Global North States to the international response effort to the pandemic WHO Director General, in May 2021, engaged the language of "vaccine apartheid" to draw attention to the actions of these States.[12] In his words:

> I think I will go one step further and say not just that the world is at risk of vaccine apartheid, the world is in vaccine apartheid. As you know high income countries account for 15 per cent of the world's population but have 45 per cent of the world's vaccines; and low- and middle-income countries account for almost half of the

[8]The original communication from India and South Africa was tabled on 2 October 2020 (*Waiver from Certain Provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of Covid-19*, WTO, UN Doc IP/C/W/669 (2020)); a revised communication with several other countries and the African group joining was tabled on 25 May 2021 (*Waiver from Certain Provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of Covid-19*, WTO, UN Doc IP/C/W/669/Rev.1 (2021)).

[9] It is worth noting that what has been negotiated bears little resemblance to the proposal India and South Africa tabled before the WTO in October 2020 (and in the revision of 25 May 2021). In the original version of the proposal, India and South Africa called for the waiver of patents, industrial designs, copyrights, and trade secrets that are guarded by WTO agreement on TRIPS. The compromise proposal that emerged indicates "some attempt to ease the burden of compulsory license mechanism for those supplying medicines and those importing medicines". The proposal will allow eligible members issue a single authorisation to waive multiple patents, including on ingredients and processes, without fear of a challenge from the patent holders. In the compromise, all countries that exported less than 10% of the world's vaccines in 2021 are eligible, which appears to exclude only China, the U.S., and the EU. It will also allow countries to export products to other eligible nations. A timeline for the length of the waiver remains to be decided. See Andrew Green, "TRIPS Waiver Compromise Draws Mixed Response" (17 March, 2022), online: <devex.com/news/trips-waiver-compromise-draws-mixed-response-102860>.

[10] Apart from the significant loss of lives, the economies of many Global South States are yet to recover from the adverse impact of the pandemic.

[11] While the bulk of the population of Global North States have been fully vaccinated with some getting booster shots, many Global South States are still struggling to get first doses out to their population. The result is that Global North States have now shifted gears and are ready to welcome a post-pandemic world with an emphasis on a return to 'new normal' while Global South States are still battling the adverse impacts of the Covid-19 pandemic. See Simar Singh Bajaj et al., "Vaccine Apartheid: Global Cooperation and Equity" (2022) 399 Lancet 1452.

[12] Emma Frage & Michael Shields, "World Has Entered a Stage of 'Vaccine Apartheid' – WHO Head" (17 May 2021), online: <reuters.com/business/healthcare-pharmaceuticals/world-has-entered-stage-vaccine-apartheid-who-head-2021-05-17/>.

> world's population but have received just 17 per cent of the world's vaccines. The gap is really huge ...[13]

This characterisation caught on, with many joining to denounce Global North States for practicing "vaccine apartheid".[14] It is however doubtful that the vocabulary of apartheid appropriately described what transpired or helped to alter the behavior of these states by producing the shock-value that was most likely intended by its usage. Two alternative conclusions offer themselves: (1) Global North States deliberately engaged in apartheid[15] and thereby trivialised[16] an otherwise consequential act of international criminality;[17] or (2) what has transpired is not apartheid but something else entirely, but equally harmful. If the latter, the next line of enquiry will be understanding why Global North States have behaved in this manner without regard for the right to health of citizens of Global South States.[18]

As a foundational proposition, the view that Global North States engaged in a form of apartheid (vaccine apartheid) is argued to be incorrect and unsupported by conventional understanding of apartheid systems under international law. Through the exploration of hard and soft law instruments the paper aims to clarify the conventional understanding of apartheid systems and practices under international law, thereby challenging the basis of the claim that Global North States have engaged in vaccine apartheid. The paper further argues that a more plausible explanation is that the behaviour of Global North States has been enabled and sustained by existing structures of global health governance which are deeply rooted in coloniality. This has led to the othering of "Third World peoples," thereby generating 'pathologies of suffering and vulnerabilities'[19] in their encounter with global health governance

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[13] Reuters, "WHO Says World Has Entered Stage of 'Vaccine Apartheid'" (17 May 2021), online (video): <youtube.com/watch?v=FxMdIL6qERk>.

[14] See Bajaj et al, *supra* note 11; United Nations, "UN Expert Urges States to End 'Vaccine Apartheid'" (14 June 2022), online: <ohchr.org/en/press-releases/2022/06/un-expert-urges-states-end-vaccine-apartheid; Roojin Habibi et al, "The HIV/AIDS Crisis Showed Us How to Equitably Overcome a Pandemic," (19 January 2022), online: <theglobeandmail.com/opinion/article-the-hivaids-crisis-showed-us-how-to-equitably-overcome-a-pandemic>.

[15] By their virtue of their selfish hoarding of life-saving vaccines and refusal to yield to the request for waivers to the TRIPS regime to allow cheaper access to the Covid-19 vaccines by Global South States. See Bajaj et al, *supra* note 11.

[16] What is suggested to have been trivialised is the crime of apartheid under international law which is viewed with the highest level of reprobation. The paper by no means suggests that hoarding vaccines and limiting access to those in need is not an equally egregious act of international wrongdoing.

[17] *International Convention on the Suppression and Punishment of the Crime of Apartheid*, UNGA, UN Doc A/9030 (1974) GA Res 3068 A (XXVIII) [Apartheid Convention] Art II defines the crime of apartheid.

[18] The right to health encourages regard for principles of international solidarity and cooperation in advancing health capabilities of all peoples regardless of geographical location, national identity, or any other distinguishing factor.

[19] I borrow from Paul Farmer's work to coin this expression. See Paul Farmer, "Pathologies of Power: Rethinking Health and Human Rights" (1999) 89:10 American J Public Health 1486.

frameworks. In concluding, the paper offers suggestions on what it would entail for Third World lives to be taken more seriously. Additionally, a tentative outline of the priorities for a decolonised global health governance framework is mapped out.

II. GLOBAL NORTH STATES DID NOT ENGAGED IN VACCINE APARTHEID

What exactly is apartheid? And how does it relate (or not) to Covid-19 vaccine? The *International Convention on the Suppression and Punishment of the Crime of Apartheid* (Apartheid Convention), which entered into force on July 18, 1976, and binds 110 states formally[20] defines "the crime of apartheid" in Art II as "…applying to the following inhuman acts committed for the purpose of establishing and maintaining domination by one racial group of persons over other racial group of persons and systematically oppressing them…."[21] The provision goes on to list the following acts: (1) denial of the right to life and liberty to members of a racial group (the methods identified for doing so include murder, infliction of serious bodily or mental harm, and arbitrary arrest and illegal imprisonment); (2) deliberate imposition on a racial group of living conditions calculated to cause their physical destruction in whole or part; (3) legislative or other measures aimed at preventing a racial group from participating in the political, economic and cultural life of the country or denying them basic rights and freedoms; (4) measures designed to divide the population along racial lines by the creation of separate reserves and ghettos for members of a racial group, prohibiting mixed marriages and expropriating land; (5) exploitation of the labour of members of a racial group, especially through forced labour; and (6) persecution of organisations or persons who oppose apartheid.

Many of the elements involved in the denial of access to vaccines could fit within this list. More specifically, the definition includes denial to racial groups of the right to life. This is apposite in the vaccine context as many Global South citizens died due to the inability to get vaccinated.[22] The question to be answered, however, is whether hoarding of vaccines by Global North States (far more than they require) qualify as denial to racial groups (and what racial groups are being denied) of the right to life? Here lies the difficulty of establishing international criminality in the form of the crime of apartheid, against Global North States. Without doubt,

[20] See Apartheid Convention, *supra* note 17.
[21] *Ibid*.
[22] Obiora Chinedu Okafor, "Panel on Vaccine Apartheid (Legal Voices Conference" (13 November 2021), online (video): <youtube.com/watch?v=uuYAxParchE>; multiple data sets have tracked the mortality rates arising from Covid-19. While Sub-Saharan African States appeared to have been relatively spared of high mortality rates, the collateral damage on the health system and economy for these states was more severe, with many not fully recovered from the aftershocks. See Robert Colebunders & Joseph Nelson Siewe Fodjo, "Covid-19 in Low and Middle Income Countries" (2022) 11:11 Pathogens 1325.

an extremely egregious harm has been caused to Global South States by the hoarding of vaccines by Global North States. But when we consider the methods listed in Art II of the Apartheid Convention for the crime of denial of right to life to occur, it seems the acts contemplated in the treaty involves far more deliberation and intent to procure the objectives of murder than was present in the act of hoarding vaccine doses by Global North States.

While the analysis thus far is inclined towards the conclusion that the crime of apartheid was not committed through the hoarding of vaccines by Global North States, there were no doubt serious breaches of existing international law obligations that came about from that action. International law obligations and solidarity principles requiring cooperation in the health context were breached. Beginning with the *Universal Declaration of Human Rights* (UDHR),[23] Art 28 is extremely clear in guaranteeing an entitlement to an international order in which the rights and freedoms set forth in the Declaration can be fully realised. In the specific context of health, Art 25 guarantees the right to a standard of living adequate for the health and well-being of individuals including medical care and necessary social services. While the UDHR is formally non-binding, it is customary international law and binds every State.

The *International Covenant on Economic, Social and Cultural Rights* (ICESCR), Art 2(1), is even more explicit, and binds 171 States that have ratified the treaty (including many Global North States). It requires State Parties to the Covenant to "take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of available resources, to achieve progressively the rights in the covenant which includes the right to health".[24] General Comment 3, which interprets the precise nature of State Parties obligations under Art 2(1) of the ICESCR, identifies two obligations, among many others, that are consequential. The first is the "undertaking to guarantee that relevant rights will be exercised without discrimination";[25] the second is the "undertaking to take steps which is not qualified or limited by other considerations".[26] In the context of the first obligation, it is clear the act of hoarding vaccines by Global North states runs afoul of this obligation. In the context of the second obligation to take steps, the means to be used to satisfy the obligation are stated in Art 2(1) to be "all appropriate means, including particularly the adoption of legislative

[23] *Universal Declaration of Human Rights*, UNGA, 3rd Sess, UN Doc A/810 (1948) GA Res 217 A (III).
[24] *International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights and Optional Protocol to the International Covenant on Civil and Political Rights*, UNGA, 21st Sess, UN Doc A/6516 (1966) GA Res 2200 (XXI) at Art 2(1); the right to health is protected under Art 12 of the ICESCR.
[25] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, UN Doc E/1991/23 (1991) [General Comment 3].
[26] *Ibid*.

measures".[27] The refusal to adopt waivers to the TRIPS regime to allow the accessibility of Global South States to cheaper versions of the Covid-19 vaccine will arguably count as a violation. This view finds support in the statements released by the Committee on Economic, Social and Cultural Rights on the Covid-19 pandemic.[28]

A final element of Art 2(1) which requires attention is the condition that all State Parties undertake "to take steps, individually and through international assistance and cooperation, especially economic and technical…".[29] General Comment 3 notes that the phrase "to the maximum of its available resources" was intended by the drafters of the Covenant to refer to both the resources existing within a State and those available from the international community through international cooperation and assistance. The essential role of such cooperation was to facilitate the full realization of the relevant rights in the Covenant.[30] Article 23 of the ICESCR reinforces this view as it specifically identifies "the furnishing of technical assistance" as well as other activities, as being among the means of "international action for the achievement of the rights recognised in the Covenant.[31] From whatever prism we view things, it is clear that Global North States acted inconsistently with these obligations. Firstly, by their refusal to share technical knowledge around the manufacture of Covid-19 vaccines with Global South States. Secondly, by refusing to accommodate requests for waivers to the TRIPS regime – a regime that gave prominence to the intellectual property rights of pharmaceutical companies of Global North States at the expense of the global protection of the right to health.

Although it has become apparent that the crime of apartheid did not arise from the actions of Global North States in their international response to the Covid-19 pandemic, there is little room for doubt that egregious breaches of other norms of international human rights law have occurred. One then wonders what has enabled and sustained these egregious breaches of international human rights law on a massive scale by Global North States.

III. GLOBAL HEALTH GOVERNANCE REMAIN IN THE CLUTCHES OF THE COLONIAL

Global health's colonial origins have played (and continue to play) a significant role in shaping its character and orientation, its focus and priorities, and its vectors and victims. This has given

[27] *Ibid* at para 3.
[28] See *Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights*, CESCR, 2020, UN Doc E/C.12/2020/1; Statement on Universal and Equitable Access to Vaccines for COVID-19, CESCR, 2020, UN Doc E/C.12/2020/2.
[29] ICESCR, *supra note* 24, Art 2(1).
[30] General Comment 3, *supra* note 25 at para 13.
[31] *Ibid*.

rise to global health governance frameworks that seldom produce outcomes that reflect the imperatives of redressing health inequities and strengthening health capabilities in all geographies of the world. The rest of this section of the paper is devoted to unpacking these claims.

A. GLOBAL HEALTH'S COLONIAL ORIGINS

Global health evokes a sense of unity and interdependence of all nations of the world in pursuing objectives of good health without any geographical boundaries.[32] This perception cloaks global health in a toga of legitimacy and elides the colonial origins that root and animate modern global health work. Global health's origin traces to the late nineteenth century marked by a period of aggressive colonial expansion by European nations, during which rival colonial powers partitioned colonial territories among themselves.[33] Despite their competing interests, these nations viewed themselves as engaged in a 'civilizing mission' to the people whom they colonised.[34] During the same period, new scientific insights into microbiological basis of many diseases by the likes of Robert Koch and Louis Pasteur revolutionised the field of medicine.[35] The convergence of these developments would give birth to what was alternatively termed tropical or colonial medicine, a field that grew and was nurtured by the need to tame diseases that sickened the colonial administrators that were sent to distant shores as well as the local populations whose labour they exploited.[36] Early disciples of global health were driven to identify the pathogens responsible for such scourges as malaria and sleeping sickness, which had earned tropical Africa the moniker of 'white man's grave'[37] and to develop treatments for them.[38]

Tropical medicine not only operated in the service of colonial exploitation, notes Mariam Fofana, it was itself an exploitative practice.[39] As documented in her study of medical research in the colonial era, Helen Tilley notes that there were few, if any ethical standards for research in the colonial era. Physicians dedicated to researching and controlling sleeping sickness engaged in mass forced displacement, unnecessary procedures, and administration of

[32] See Mariam O. Fofana, "Decolonising Global Health in the Time of Covid-19" (2020) 16:8-9 Global Public Health 1155 at 1157.
[33] *Ibid*.
[34] Deborah J Neil, *Networks in Tropical Medicine: Internationalism, Colonialism, and the Rise of a Medical Speciality, 1890-1930* (Stanford, CA: Stanford University Press, 2012).
[35] Fofana, *supra* note at 27, 1156.
[36] *Ibid*.
[37] Philip D Curtin, "'The White Man's Grave:' Image and Reality" (1961) 1:1 J British Studies 94.
[38] Neil, *supra* note 29 at 13—19.
[39] Fofana, *supra* note 27 at 1156.

highly toxic drugs.[40] Yet they likely viewed themselves as saviours, advancing science and saving vulnerable populations that could not otherwise protect themselves from disease.[41]

B. GLOBAL HEALTH'S CHARACTER AND ORIENTATION AS SHAPED BY ITS COLONIAL ORIGINS

The character and orientation of modern global health is better appreciated when account is taken of the transition from the era of tropical medicine to the present era of modern global health. In his commentary in the *Lancet*, Richard Horton points to the erasure of important histories and the marginalisation of already neglected peoples which has prevented accurate understanding of why progress towards sustainable health improvements in some of the most resource-poor settings is slow and erratic.[42] Horton uses the example of two publications in 2013 in *The New England Journal of Medicine* to illustrate his point about the erasure of history in global health. Both publications sought to explain the emergence of global health and how global health should evolve in the future.[43] The first by Allan Brandt, a distinguished Harvard medical historian, argued that the HIV epidemic and the responses it generated were crucial forces in inventing the new global health. He claimed that AIDS disrupted old thinking in international health and unleashed a new era of activism that put those living with the disease at the forefront of advocacy. This triggered unrivalled investments in health, led to the creation of new public, private, and philanthropic global health institutions, and contributed substantially to the central place of health in the UN-led Millennium Development Goals. Brandt concludes that without the HIV epidemic there will be no global health movement as we know it.[44] A companion paper by Peter Piot and Thomas Quinn argued that the "unprecedented global response to the AIDS pandemic can serve as a paradigm for the response to other global health threats".[45]

While acknowledging that the HIV epidemic has been (and continues to be) an important force in shaping global health, Horton correctly notes that "it is an error to assign a

[40] We were reminded of this colonial past in the suggestion that was made by two French doctors on a French television channel to test the early development of the Covid-19 vaccine on Africans. See Rebecca Rosman, "Racism Row as French Doctors Suggest Virus Vaccine Test in Africa" (4 April 2020), online: <aljazeera.com/news/2020/4/4/racism-row-as-french-doctors-suggest-virus-vaccine-test-in-africa>.
[41] Helen Tilley, "Medicine, Empires and Ethics in Colonial Africa" (2016) 18:7 AMA J Ethics 743.
[42] Richard Horton, "Offline: Frantz Fanon and the Origins of Global Health" (2018) 392 Lancet 720.
[43] *Ibid*.
[44] Allan M Brandt, "How AIDS Invented Global Health" (2013) 368 New England J Medicine 2149; referred to in Horton, *supra* note 36.
[45] Peter Piot & Thomas C. Quinn, "Responses to the AIDS Pandemic – A Global Health Model" (2013) 368 New England J Medicine 2210; referred to in Horton, *supra* note 36.

single disease as its point of origin. To do so jeopardises efforts to advance health, liberty, and equity for the most disadvantaged communities on the planet."[46] Engaging a broader lens to view global health allows us to see what is hidden about the character and orientation of global health. To this point, Horton argues that we should adopt a lens that views global health not merely as a constellation of diseases of national health systems, or even a set of values. Rather it is a way of looking at our world, seeking to observe, document, monitor, interpret, and eliminate the harms that accrue from national and transnational forces inimical to health – political, commercial, military, financial, diplomatic, legal, intersectional, and cultural.[47] In summing up, Horton observes, and agreeably so, that:

> Global health is about power and poverty, violence and exploitation, oppression and silence, and collusion and exclusion. If one views global health using this broader lens, the historical turn that was the decisive creative moment for the birth of global health was surely decolonisation. It was decolonisation, beginning in the 1950s with the legacies that continue to this day, which illuminated the myriad pressures that shape the health of peoples worldwide.[48]

C. GLOBAL HEALTH'S FOCUS AND PRIORITIES AS DEEPLY ROOTED IN COLONIALITY

Fofana makes an important observation: "if crisis is revealing of true character, the COVID-19 pandemic has certainly engendered a moment of truth".[49] This paper suggests, in agreement with Fofana, that this moment of truth is the realisation that global health governance remains deeply rooted in coloniality.[50] Anthropologist Eugene Richardson defines coloniality as "the matrix of power relations that persistently manifests transnationally and intersubjectively despite a former colony's achievement of nationhood", the "hierarchical orders imposed by European colonialism that have transcended 'decolonisation' and continue to oppress".[51] This understanding equips Global South States with the appropriate lens to interpret their encounter with global health governance and actors ensconced in Global North States.[52] What is hidden by sleight of hand becomes revealed for what it is. Thus, random acts of lack of solidarity by

[46] Horton, *supra* note at 36.
[47] *Ibid*.
[48] *Ibid*; for an interesting reading of the impact of the colonial on modern global health, see Seye Abimbola, "On the Meaning of Global Health and the Role of Global Health Journals" (2018) 10 Intl Health 63.
[49] Fofana, *supra* note 27 at 1162.
[50] *Ibid* at 1158—60.
[51] Eugene T Richardson, "On the Coloniality of Global Public Health" (2019) 6:4 Medicine & Anthropology Theory at 101—118.
[52] On this point see Abimbola et al, *supra* note 6.

Global North States like: (1) hoarding vaccines beyond what is required; (2) refusing to waive intellectual property rights under the TRIPS regime to allow the production of cheaper Covid-19 vaccines by Global South States; (3) declaring the pandemic over and pushing for a return to normal after vaccinating and boosting most of their population (ignoring the fact that at the time, many Global South States were still struggling to get first doses of the Covid-19 vaccine out to their population); and (4) refusing to make accommodations to ensure systemic, structural and economic inequities and inequalities that were worsened by Covid-19 were addressed etc., can be seen in a new light. Namely, a reflection of the focus and priorities of global health governance as vectors for enabling and sustaining *violence and exploitation, oppression and silence, and collusion and exclusion*.

D. GLOBAL HEALTH'S VECTORS OF COLONIALITY AND ITS VICTIMS

In epidemiology, vectors are organisms that transmit diseases to other living organisms.[53] In the context of the focus of this paper, this is metaphorised to capture the process by which global health governance has enabled and sustained coloniality. Victims, in this context, are those at the receiving end of coloniality.

First, the lack of diversity of many global health institutions, which is well documented in the literature,[54] has made these institutions suitable vectors of coloniality. Anu Kumar writes in this regard that:

> In the global health and human rights community, where I sit professionally, there's been a lot of discussion in the last few years about decolonising global health. What we don't talk about explicitly enough, however, is how white supremacy operates in this sector. In many cases, we focus on diversity, equity and inclusion, mentorship, and funding strategies – which are all important. What we don't talk about is how the structures and operations of our organisations are part of white supremacist culture. We don't talk about how white people and those who center whiteness, including me, support policies and programs that perpetuate neo-colonialism. I say this even as a woman of colour leading an organisation with staff who speak multiple languages and come from different backgrounds. White

[53] Institute of Medicine of the National Academes, *Vector-Borne Diseases: Understanding the Environmental, Human Health, and Ecological Connections*: *Workshop Summary* (Washington, DC: National Academies Press, 2008).

[54] See Anu Kumar, "White Supremacy in Global Health" (18 June, 2020), online: <thinkglobalhealth.org/article/white-supremacy-global-health>; see also Abimbola et al, *supra* note 6; and Fofana, *supra* note 27.

> supremacist culture is so powerful, and we are rewarded in so many ways for conforming to it, that we are sometimes blind to its influence.[55]

Second, the localisation of most global health institutions in the Global North excludes the Global South or assigns Global South States to the periphery when important decisions about global health policies and actions are being tabled, designed, and implemented.[56] Third, the leaders of global health institutions are (more often than not) men, more than 80% are nationals of Global North States, and more than 90% were educated in Global North States.[57] Fourth, Global North States account for majority of global health spending, and by virtue of controlling the purse strings, they effectively control the global health agenda.[58] Fifth, global health research agenda is controlled by Global North scholars.[59] In addition, global health journals lack diversity.[60] This has led to the exclusion of Global South perspectives in the knowledge mobilisation for global health action. Sixth, and lastly, "far too often, international donors and funding organisations who come as 'saviours,' prefer to fund projects that address their own interests, on their own terms. This in turn, leads to a waste of resources, loss of local research interest, and lack of trust between grantees and donors."[61]

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[55] Anu Kumar, *supra* note 48.

[56] Available data show that 85% of global health institutions are headquartered in Global North States where major decisions impacting global health are made. See Global Health 50/50, "The Global Health 50/50 Report 2020: Power, Privilege and Priorities" (2020), online: <globalhealth5050.org/wp-content/uploads/2020/03/Power-Privilege-and-Priorities-2020-Global-Health-5050-Report.pdf>.

[57] *Ibid*.

[58] Joseph L Dieleman et al, "Global Health Spending and Development Assistance for Health" (2019) 321:21 JAMA 2073.

[59] The *Lancet* commissions, for example, are dominated by Global North experts, and a vast majority have secretariats based in Global North universities (Manuel W Hetzel & Bassirou Bonfah, "Towards More Balanced Representations in Lancet Commissions (2020) 395 Lancet 1693; awards in global health are mostly given to men and experts from the Global North (Emily MacLean et al, "Global Tuberculosis Awards Must Do Better With Equity, Diversity, and Inclusion" (2021) 397 Lancet 192.

[60] Madhukar Pai, "How Prestige Journals Remain Elite, Exclusive and Exclusionary" (30 November 2020), online: <forbes.com/sites/madhukarpai/2020/11/30/how-prestige-journals-remain-elite-exclusive-and-exclusionary/?sh=12ae2e334d48>.

[61] Abimbola et al, *supra* note 6, 7; Even when research work is focused entirely in the Global South, much of donor funds are given to agencies and institutions in the Global North and Global North States hold the purse strings (see Dieleman et al, *supra* note 52); for example, less than 2% of all humanitarian funding goes directly to local NGOs (see Bibi van der Zee, "Less than 2% of Humanitarian Funds 'Go Directly to Local NGOs'" (16 October 2015) online: <theguardian.com/global-development-professionals-network/2015/oct/16/less-than-2-of-humanitarian-funds-go-directly-to-local-ngos>; about 80% of USAID's contracts and grants go directly to United States firms (Kenan Malik, "As a System, Foreign Aid is a Fraud and Does Nothing for Inequality" (2 September 2018), online: <theguardian.com/commentisfree/2018/sep/02/as-a-system-foreign-aid-is-a-fraud-and-does-nothing-for-inequality>; 70% of NIH Fogarty grants go to US and Global North institutions (Roger I Glass, "Decolonizing and Democratizing Global Health are Difficult, But Vital Goals" (2020) 19:4 Global Health Matters 1 at 10); and 73% of the total international grant portfolio of the Welcome Trust supports United Kingdom-based activity (Wellcome Trust, "Grant Funding Data Report 2018/19" (March 2020), online: <wellcome.org/sites/default/files/grant-funding-data-2018-2019.pdf>. Even when funds given to Global South agencies or researchers, Global North donors often set the agenda and micromanage the work, leaving little room for Global South groups to innovate.

In sum, the entire value chain of institutional staffing, location, leadership, funding control, knowledge mobilisation, and donor practice of global health institutions and actors are controlled by Global North States. This has made it relatively easy for the priorities and agenda of Global North States to dominate, to the exclusion of Global South priorities and agenda in the praxis of global health governance frameworks. Thus, leading to the *centering* of the Global North and *othering* of the Global South in global health thought and action.

IV. DECOLONISING GLOBAL HEALTH GOVERNANCE TO PROMOTE HEALTH CAPABILITIES IN THE GLOBAL SOUTH

A. EXPLAINING THE LENS OF THE PAPER

This paper has used the descriptor 'Third World' interchangeably with the Global South. This has been done intentionally with foreknowledge of the colonially charged meaning evoked by this usage. In deploying this usage, I have drawn from TWAILIAN sensibilities. TWAIL, which stands for 'third world approaches to international law' is a scholarly perspective which maps the geography of the Global South according to the way international law impacts the governed, no matter where they are spatially located.[62] Because TWAIL refuses to take international law claims of universality at face-value, it offers a useful critical lens for this paper. TWAIL's sceptical interrogation of the encounter of international law and international institutions with countries of the Third World (alternatively Global South) is not a particularly new tradition of "critical internationalism".[63] Its intellectual roots stretch back to the Afro-Asian anticolonial struggles of the 1940s-1960s, and even further back to the Latin American decolonization movements. In its renaissance, contemporary TWAIL scholarship has engaged strongly with other critical schools of international legal scholarship.[64] TWAIL scholars deploy a wide range of "analytic techniques/sensibilities in providing alternative approaches that 'assail the creation and perpetuation of international law' that subordinates the Third World in the global legal order".[65]

[62] Luis Eslava & Sundhya Pahuja, "Beyond the (Post)Colonial: TWAIL and the Everyday Life of International Law" (2012) 45:2 L & Politics in Africa, Asia & Latin America 195 at 197.
[63] Obiora Chinedu Okafor & Uchechukwu Ngwaba, "The International Criminal Court as a Transitional Justice Mechanism in Africa: Some Critical Reflections" (2014) 9:1 Intl J Transitional Justice 90 at 91.
[64] Obiora Chinedu Okafor, "Newness, Imperialism, and International Legal Reform in Our Time: A Twail Perspective" (2005) 43:1/2 Osgoode Hall LJ 171.
[65] Okafor and Ngwaba, *supra* note 63, 92.

B. THE GOAL OF HEALTH CAPABILITY

In decolonising global health governance frameworks, the key goal has been identified to be promoting health capabilities in the Global South. This would require recentering the Global South in the priorities, agendas, and praxis of global health governance frameworks. Before mapping out the specific areas where this recentering should occur, it is necessary to first explain what health capabilities entails. The formulation of health capability used in this paper draws from Amartya Sen's capability approach.[66] Amartya Sen has formulated a capability approach that is closely connected to the Aristotelian conception of social and political ethics through his emphasis on capability as the focal variable for social evaluation. Like Aristotle, Sen asserts the importance of freedom is attaching value to choice and opportunities, for individuals to live the life they choose given their personal and social circumstances.[67] The capability approach, like the Aristotelian view, focuses on the capability to lead a worthwhile life. It applies this freedom to all members of society, irrespective of race, class, gender, community, sexual orientation, or ethnicity. Capability to function, Sen argues, incorporates both well-being and the freedom to pursue well-being.[68] The capability approach encourages human agency. Promoting health capabilities in the Global South will entail promoting the agency of the Global South in the choice of the priorities, agendas, and praxis of global health governance frameworks as it impacts the population of the Global South, in the very same way this capability is available to the populations of the Global North.

C. AN OUTLINE OF PRIORITY AREAS FOR A DECOLONISED GLOBAL HEALTH GOVERNANCE

The issues discussed in Section III of this paper (on "global health's vectors of coloniality and its victims") inform identified priorities for decolonising global health governance to promote health capabilities in the Global South.

(i) From the discussion on lack of diversity in global health institutions, what is apparent is that the challenge goes beyond staffing these institutions with more persons of ethnicities representing Global South States. There is also need for a decolonisation of the mind as the most dangerous locus of colonisation is not physical, but our minds.[69] Colonisation

[66] Amartya Sen, *Inequality Reexamined* (Oxford: Oxford University Press, 1992).
[67] *Ibid*; cited in Jennifer Prah Ruger, "Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements" (2006) 18:2 Yale JL Human 1 at 13.
[68] *Ibid*.
[69] Steve Biko, *I Write What I like: Selected Writings* (London: Bowerdean Press, 1978).

was designed to insidiously permeate every aspect of our value judgments as humans.[70] To decolonise therefore, we must build deep and collective awareness of how our colonial histories have shaped our thinking and continue to influence how we see the world and our place in it. We must make conscious efforts to unlearn the idea of Western research and knowledge systems as opposed to local research and traditional/indigenous knowledge systems, as being the only way to advance healthcare or promote health capabilities in the Global South.[71]

(ii) Global health governance cannot be reformed and made more responsive to Global South priorities, agendas and praxis so long as the locale of these institutions remains in the Global North. Concerted effort must be made by Global South States to bring about a phased decentralisation of global health governance institutions. Global North States will not willingly give up their power. Global South States must push for commitments from Global North States to decentralise the institutions and organisations involved in global health governance and they should then be held accountable to these commitments.[72]

(iii) All global health institutions (in the Global North or Global South) must commit to real equity, diversity and inclusion as part of their core mission and ensure their leadership and staff are diverse and gender balanced, without which global health organisations are bound to fail in their mission. As Abimbola rightly observes, even the most well-intentioned people who claim to not have racist or supremacist biases behave in ways that undermine the expertise and knowledge of (other) local researchers, practitioners, communities, and individuals.[73]

(iv) Global South States must invest more in their own healthcare delivery system, research, and training to reduce the dependence on Global North institutions, donors, and philanthropies. Investing in the establishment of quality research and teaching institutions in the Global South is critical to reducing reliance on the Global North to improve the overall quality, depth, and relevance of scientific training and research taking place in the Global South.[74]

[70] Abimbola et al, *supra* note 6, 3.
[71] *Ibid*.
[72] *Ibid* at 8.
[73] *Ibid* at 6.
[74] *Ibid* at 8; Sejuti Saha & Madhukar Pai, "Can Covid-19 Innovations and Systems Help Low- and Middle-income Countries to Re-imagine Healthcare Delivery?" (2021) 2:4 Med 369.

V. CONCLUSION

Since the first draft of this paper was completed in 2022, a number of developments have occurred in the field of global health which further reinforce the case for decolonising the field. It is now 2024, without going into details, the pandemic was officially declared over on 5 May 2023. This was when the WHO Emergency Committee on COVID-19 recommended to the Director-General, who accepted the recommendation, "that given the disease was by now well established and ongoing, it no longer fit the definition of a Public Health Emergency of International Concern."[75] The attention of the global health community immediately turned to preparing against future pandemics. Two initiatives championed by WHO gained prominence in international deliberations: one is a proposal to revise the International Health Regulations 2005;[76] and the other is a proposal for a pandemic treaty to promote an equitable pandemic management system in global health governance.[77] May 2024 has been fixed as an ambitious date for finalising the draft treaty. While it is not likely to be met, indicators are that an ideological rift between the Global North and Global South has emerged in the negotiation process. This is due to the dilution of human rights and equity goals that initially motivated the drafting of the treaty, in favour of priorities of interest to the Global North (such as global health security and information sharing).[78] Occurrences like this convince this author that global health governance remains in urgent need of decolonisation.

[75] World Health Organization, "Coronavirus Disease (COVID-19) Pandemic", online: <who.int/europe/emergencies/situations/covid-19>.

[76] World Health Organization, "Member States Consider Proposed Amendments to the International Health Regulations with Discussions on Equity to Continue" (19 February 2024), online: <who.int/news/item/19-02-2024-member-states-consider-proposed-amendments-to-the-international-health-regulations-with-discussions-on-equity-to-continue>.

[77] World Health Organization, "WHO Member States Agree to Resume Negotiations Aimed at Finalizing the World's First Pandemic Agreement" (28 March 2024), online: <who.int/news/item/28-03-2024-who-member-states-agree-to-resume-negotiations-aimed-at-finalizing-the-world-s-first-pandemic-agreement>.

[78] Luke Taylor, "Covid-19: WHO Treaty on Future Pandemics is Being Watered Down, Warn Health Leaders" (2023) 381 BMJ 1246.