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Symposium Articles

Reflections on Decolonial Imperatives in Global Health Law

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Abstract

Global health law in theory and practice can either work to ameliorate the devastating consequences of colonialism, class hierarchies, and structural racism in health, or it can ratify and exacerbate them. It can protect, under protect, overprotect, or fail to protect – it is not and cannot be neutral. Global health law reflects the choices and practices of States and other actors, which includes both action and inaction. Inaction or silence on the part of global health law is a choice that ratifies the status quo of coloniality, class exploitation, and structural racism in health.

Keywords: global health; decolonization; structural racism; class hierarchies; colonialism

My interest in global health was sparked by the devastation wrought by the HIV/AIDS pandemic on People of the Global Majority. While working with the Global AIDS Alliance in 2003, I remember the futility I felt contributing to advocacy efforts aimed at convincing policy makers and other actors to fund initiatives like the Global Fund for AIDS, Tuberculosis, and Malaria; the US President's Emergency Plan for AIDS Relief; and non-profits like Keep a Child Alive.

Bearing witness to the 2014–2015 Ebola epidemic ransacking several West African countries, I was driven to undermine simplistic accounts where epidemics like Ebola just happen spontaneously due to local backwardness, where health inequalities and vulnerabilities are natural and inevitable, and where responses depend largely on the munificence of international actors. The HIV/AIDS pandemic and the Ebola epidemic resuscitated images of Africa as the "Dark Continent" and a barren wasteland. Yet, the response of international actors must be contextualized against the tendency to normalize the suffering and vulnerability associated with diseases that disproportionately impact Black, Indigenous, and other peoples of color.

Global health law has long rendered invisible the historical and ongoing effects of colonialism, material exploitation, and structural racism. When the field of global health law engages with inequality, it tends to do so primarily as a function of income disparities between States, without sufficient attention to historicizing or contextualizing this inequality. Thus, inequality can become routinized and normalized — the result of happenstance. It is understood that inequality in health is informed by structural determinants of health, but analyses that elide the operation of colonialism, structural racism, and class hierarchies can miss crucial ways that health inequalities are constituted globally.

Historically, global health law has reified the subaltern positions of many Black, Indigenous, and other peoples of color who lack(ed) lawmaking power nationally, regionally, or internationally. International law long provided that only States can make binding law — either through treaty or custom — and a small club of States dictated the terms of entry for other peoples to statehood. As these States founded the United Nations and World Health Organization (WHO), about a third of the world's population remained subject to colonial domination and rule. Since the WHO's inception, the issue of whether it can make a clear break from the coloniality of global health law has been a central issue shaping its work.

Global health law in theory and practice can either work to ameliorate the devastating consequences of colonialism, class hierarchies, and structural racism in health, or it can ratify and exacerbate them. It can protect, under protect, overprotect, or fail to protect — it is not and cannot be neutral. Global health law reflects the choices and practices of States and other actors, which includes both action and inaction. Inaction or silence on the part of global health law is a choice that ratifies the status quo of coloniality, class exploitation, and structural racism in health.

It remains unclear whether ongoing efforts to reform WHO, even if they are concluded, will be fit for purpose to ameliorate the health inequalities stemming from structural racism, colonialism, and class subordination. If the field aspires to decolonial futures, it is imperative that global health law engage explicitly with People of the Global Majority to consider how their relative positions have informed their health priorities and claim-making. Otherwise, global health law risks reinscribing the functioning of imperial power and reifying the subaltern positions of those who lack(ed) lawmaking power.

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