Medicus Mundi Suisse
Santé pour tous

MMS Bulletin #164

Décolonisation de la coopération en matière de santé - Réflexions sur un processus de transformation à venir

4 Thoughts on Decolonizing International Health Cooperation

Where to start?

De Estefania Cuero

There is no single answer on how and whether it is even possible to decolonize international health cooperation. By bringing together four advocacies, this article is yet an attempt to contribute to this aspiration. The premise is that the core of international cooperation is the reduction of inequality in healthcare. It invites actors to reflect on the terminology and be precise about how a certain project contributes to reducing inequality. The role of the private sector and the concentration of wealth in increasing inequality is also being addressed as well as the overdue shift from charity to reparative distribution.

Photo: © iStock.com/asiandelight *Photo: © iStock.com/asiandelight*

Terminology

Walter Rodney's book *How Europe Underdeveloped Africa* was first published in 1972. He writes that exploitation has always and in every part of the world been the core meaning of "development" (Rodney, 1972). For colonial powers, the idea that "development" can also serve the well-being of people living elsewhere, gained relevance just in the first half of the 20th century. Still today, our understanding of "development" and "development cooperation" is shaped by discourses that have been defined by colonial power relations (Ziai, 2016). The heritage of the colonial discourse cannot only be found in the 17 Sustainable Development Goals (SDGs) (UN General Assembly, 2015) or in individual cooperation projects, but also in the terminology itself. It entails the construction of identities, epistemic violence for legitimizing politico-economic actions and the promotion rather than reduction of structural inequality (McCarthy, 2015; Ziai, 2014 & 2016).

Aram Ziai explains that the essence of "development" nowadays is to foster social, political, and economic transformation in order to reduce social inequality on a global scale. He nevertheless advocates to desist from the term and to stop simplifying complex economic, ecologic, and social relations or the homogenization of areas that have nothing in common

except for a more or less comparable colonial experience. A different term cannot undo the colonial marks and other negative connotations. Instead, he suggests indicating more specifically what we are referring to (Ziai, 2014).

> *For colonial powers, the idea that "development" can also serve the well-being of people living elsewhere, gained relevance just in the first half of the 20th century. Still today, our understanding of "development" and "development cooperation" is shaped by discourses that have been defined by colonial power relations.*
>
> —

Switzerland's Federal Department of Foreign Affairs states that "[i]nternational cooperation includes development cooperation with the South and the East" and considers health as one of its subjects (FDFA, 2018). In this article, international health cooperation is therefore understood as embedded in contemporary development discourse. This leaves us with the following questions:

- What do we mean when we speak of international health cooperation?
- What concrete actions are taken to implement international health cooperation?
- How does the discipline or project at hand contribute to the reduction of inequality in healthcare systems?

In its briefing note, Oxfam summarized how the International Finance Corporation (IFC), a private sector financing arm of the World Bank Group, had abandoned its proposition to offer "vastly improved, high-quality healthcare services for the same annual cost as the old public hospital" in Lesotho. By the time the briefing note was published, its services had used up the triple amount of what the former public hospital would have cost and consumed over 50% of the government's health budget. The private provider also failed by "diverting urgently needed resources from primary and secondary healthcare in rural areas" in which most of the population lives and increasing mortality rates were documented. In 2014, the public-private partnership hospital and its three filter clinics were expected to have an income almost 8 times higher than the initial investment (Oxfam, 2014).

> *Therefore, a first step towards decolonizing international health cooperation is to refrain from terms that obscure colonial and exploitative continuities by mingling them with concepts such as "aid."*
>
> —

This example illustrates that the ideas, goals, and interests behind an investment from the International Finance Cooperation for private health providers might not be the same as the ones from a local NGO with a focus on women's reproductive rights. Interests and actions that fall under the umbrella of "international health cooperation" might not even contribute to reducing inequality at all. Therefore, a first step towards decolonizing international health cooperation is to refrain from terms that obscure colonial and exploitative continuities by mingling them with concepts such as "aid."

Photo: © iStock.com/ImagePixel

Private Actors

In October 2022, twenty civil society organizations addressed their concerns on human rights harms related to the privatization and commercialization of healthcare in Kenya in a joint submission to the United Nations. They report that IFC representatives denied their responsibility to consider whether patients can afford health services or not. Whereas USAID admitted the "pro-rich bias of the private sector" and expressed its acceptance by further promoting projects with a precedence to the rich (Amnesty International Kenya, et al., 2022).

According to Alicia Ely Yamin, the SDGs fail to take up the powerful role of the private sector and an apparatus that secures accountability. The neoliberal orientation to entrust the private sector with implementing and financing the SDGs makes accountability mechanisms the more important (Yamin, 2019). The "Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare" by The Global Initiative for Economic, Social and Cultural Rights entails a list of human rights concerns linked to the privatization in health

services in over 30 countries (The Global Initiative, 2021). Moreover, the distraction from state responsibility contradicts the demands of the civil society, which Yamin addresses with a focus on sexual and reproductive health and rights (Yamin, 2019).

Practitioners in international healthcare projects are therefore invited to promote measures to hold private actors in the field accountable.

> *The "Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare" by The Global Initiative for Economic, Social and Cultural Rights entails a list of human rights concerns linked to the privatization in health services in over 30 countries.*

—

Wealth Concentration

After the Cold War, neoliberalism became the dominant politico-economic strategy in national and global economies, in favor of the wealthy. Parallel to that, the endeavors for material justice decreased to basic human rights provisions (Moyn, 2018). Until today, the discourse of "development cooperation" does not address extreme wealth as opposed to extreme poverty nor how the concentration of wealth maintains and fosters inequality (Donald & Martens, 2018; Odera & Mulusa, 2020).

The SDGs are a consequence as well as a carrier of this circumstance. The 10th Sustainable Development Goal of reducing inequality in and between countries misses one indicator that demands states to reduce the unequal distribution of income and wealth in and between countries. In the measurement of inequality, the focus lies on the exclusion of marginalized groups and the lack of equal opportunities. The problem of extreme inequality due to the concentration of wealth is completely avoided, which is why the indicators can hardly do justice to the goal they monitor (Fukuda-Parr, 2019).

The seemingly neutral metrics of indicator sets to monitor the progress of the SDGs also serve to veil political interests and ideologies. How these indicators are formulated and agreed upon is highly political, not least because it influences the knowledge production evolving around "development cooperation" with data playing a central role. What data is collected and how it is described and interpreted is an expression of power that again results in narratives on development and cooperation (Yamin, 2019).

The foundation of today's unequal distribution of wealth lays in the colonial project. Practitioners interested in decolonizing cooperation can complement the focus on basic health services by producing and disseminating knowledge on extreme wealth concentration and its impact on global healthcare.

> *Until today, the discourse of "development cooperation" does not address extreme wealth as opposed to extreme poverty nor how the concentration of wealth maintains and fosters inequality.*

—

Photo by Joel Muniz on Unsplash

Distribution

Audrey Chapman argues, among others, in favor of distributional endeavors for universal health coverage such as tax revenues and compulsory schemes to subsidize healthcare (Chapman, 2016). The take of "compulsion" to provide universal healthcare as presented by Chapman contradicts the idea of global health as a matter of charity and saviorism (Abimbola & Pai, 2020). "The small number of private sector programs that improve access for marginalized communities in most cases are developed and operated by philanthropic organizations or not-for-profits," (Chapman, 2014). As Benjamin Haas shares from own experience, the "donor image" comes with "a feeling of superiority" and the expectation of gratefulness (Haas, 2014). This seems far easier than working towards the vision described by Seye Abimbola and Madhukar Pai:

To decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level. […] Supremacy is there in persisting colonial and imperialist (European and otherwise) attitudes, in stark and

disguised racism, White supremacy, White saviourism, […] and much more. (Abimbola & Pai, 2020)

One of these persisting colonial attitudes is the refusal to compensate. Even though compensations became an undisputable component of international law-making, in over 400 years of exploitations there have not been any meaningful reparations to former colonial regions. The willingness to pay for crimes remained limited to particular contexts, despite the compatibility of reparations and capitalist logic. The African World Reparations and Repatriations Truth Commission estimates that the due amount of reparations for the enslavement and murder of Africans as well as the exploitation of natural resources is USD 777 trillion (Ziai, 2016).

A short look into the search engine's results shows how actors in international health cooperation attend to saviorism by selling the experience of helping the infantilized other with a charitable donation. Instead, they could address a commitment to distributive and reparative justice and its relevance for the improvement of healthcare. The perversion of how persistent actors hang on to this narrative becomes clearer when we consider that – in addition to well-known colonial atrocities such as genocide, rape, and enslavement – diseases were intentionally disseminated by regrouping indigenous people to extinguish entire tribes (Milliken & Le Tourneau, 2020).

Consequently, a third step in decolonizing international health cooperation is to forward reparative justice with two parallel approaches. The first being to promote mandatory distributive justice to reduce inequality in healthcare. The second encourages a culture and mentality in which the willingness to distribute comes from the sense of responsibility instead of a feeling of superiority. In such settings, we would speak of reparations and distributive justice in international healthcare projects rather than of donations.

> *To decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level. […] Supremacy is there in persisting colonial and imperialist (European and otherwise) attitudes, in stark and disguised racism, White supremacy, White saviourism, […] and much more.*
>
> — *Abimbola & Pai, 2020*

Closing Remarks

In the style of Ziai's critique of the development discourse: As long as societies are compared and evaluated by means and narratives that are tainted by colonial thought, the following actions remain a mere contribution to harm reduction.

- To reflect on the terminology and be more specific about how a certain project contributes to reducing inequality.
- To promote measures that hold private actors accountable.
- To challenge the concentration of wealth.
- To encourage a culture with a decolonial understanding of responsibility and promote mandatory distributive justice to reduce inequality in healthcare.

Provided that there is a broad rejection of such means and narratives, these suggestions can serve as a contribution to decolonizing and transforming healthcare on a global scale.

> *One of these persisting colonial attitudes is the refusal to compensate. Even though compensations became an undisputable component of international law-making, in over 400 years of exploitations there have not been any meaningful reparations to former colonial regions.*
>
> —

References

- Abimbola, S. & Pai, M. (2020). "Will global health survive its decolonisation?". Perspectives – The Art of Medicine. Vol. 396, Nr. 10263. Available from: https://doi.org/10.1016/S0140-6736(20)32417-X.
- Amnesty International Kenya, et al. (2022). Joint submission regarding human rights harms associated with the privatization and commercialization of healthcare in Kenya. Available from: https://chrgj.org/publication/joint-submission-regarding-human-rights-harms-associated-with-the-privatization-and-commercialization-of-healthcare-in-kenya/.
- Chapman, A. (2014). "The Impact of Reliance on Private Sector Health Services on the Right to Health". Health and Human Rights Journal. Vol. 16, Nr. 1. https://www.hhrjournal.org/2014/07/the-impact-of-r...
- Chapman, A. (2016). Global health, human rights, and the challenge of neoliberal policies. Cambridge: Cambridge University Press.
- Donald, K. & Martens, J. (2018). "The increasing concentration of wealth and economic power as an obstacle to sustainable development – and what to do about it". In: Eds. B. Adams, R. Bissio, et al. Spotlight on Sustainable Development 2021 – Demanding justice beyond rhetoric. Bonn: Civil Society Reflection Group. Available from: https://www.2030spotlight.org/en/book/1730/chapter/1-increasing-concentration-wealth-and-economic-power-obstacle-sustainable.
- FDFA – Swiss Federal Department of Foreign Affairs (last updated: 2018). FAQs International Cooperation. Available from: https://www.eda.admin.ch/deza/en/home/sdc/faqs/faq-unterschied.html.

- Fukuda-Parr, S. (2019). "Keeping Out Extreme Inequality from the SDG Agenda – The Politics of Indicators". Global Policy. Vol. 10, Nr. 1. Available from: https://doi.org/10.1111/1758-5899.12602.
- Haas, B. (2014). "Weiße Wohltätigkeit oder globale Solidarität?". In: Ed. ICJA Freiwilligenaustausch weltweit e. V. Spende gut, alles gut? Kritische Perspektiven auf Spenden von internationalen Freiwilligen aus dem Globalen Norden im Nord-Süd-Kontext. Berlin: ICJA. Available from: https://www.icye.org/publications/.
- McCarthy, T. A. (2015). Rassismus, Imperialismus und die Idee menschlicher Entwicklung. Translated by M. Müller. 1st edition. Berlin: Suhrkamp.
- Milliken, W. & Le Tourneau, F. (2020). "Covid-19, isolated indigenous peoples and the history of the Amazon". The Conversation. Available from: https://theconversation.com/covid-19-isolated-indigenous-peoples-and-the-history-of-the-amazon-136090.
- Moyn, S. (2018). Not enough: human rights in an unequal world. Cambridge, Massachusetts: The Belknap Press of Harvard University Press.
- Odera, J. A. & Mulusa, J. (2020). "SDGs, Gender Equality and Women's Empowerment: What Prospects for Delivery?". In: Eds. M. Kaltenborn, M. Krajewski, H. Kuhn. Sustainable Development Goals and Human Rights. Cham: Springer.
- Oxfam (2014). "A Dangerous Diversion. Will the IFC's flagship health PPP bankrupt Lesotho's Ministry of Health?". Briefing Note. Oxford: Oxfam GB.
- Rodney, W. (1972). How Europe Underdeveloped Africa. Harare, Zimbabwe: Zimbabwe Pub. House.
- The Global Initiative for Economic, Social and Cultural Rights (2021). Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare. Synthesis paper. Version 4. Latest revision June 2021. Available from: https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare.
- UN General Assembly (2015). Transforming our world: the 2030 Agenda for Sustainable Development. A/RES/70/1. Available from: https://sdgs.un.org/2030agenda.
- Yamin, A. E. (2019). "Power, Politics and Knowledge Claims: Sexual and Reproductive Health and Rights in the SDG Era". Global Policy. Vol. 10, Nr. 1. Available from: https://doi.org/10.1111/1758-5899.12598.
- Ziai, A. (2014). "Im Westen nichts Neues? Stand und Perspektiven der Entwicklungstheorie". In: Ed. A. Ziai. Im Westen nichts Neues? Stand und Perspektiven der Entwicklungstheorie. 1st edition. Baden-Baden: Nomos.
- Ziai, A. (2016). Development Discourse and Global History: From Colonialism to the Sustainable Development Goals. New York: Routledge.

Estefania Cuero *is currently a PhD Student at the University of Lucern. She has a MA in Human Rights and Cultural Diversity from the University of Essex and has work experience in international organizations and NGOs. Furthermore Estefania is a diversity coach with*

a focus on antiracism and decolonization (www.cuero.ch) and she is a member of the Swiss Young Academy. Email

Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Route de Ferney 150
CP 2100
CH-1211 Genève 2
Tél. +41 22 920 08 08
contact@medicusmundi.ch

Coordonnées bancaires
Basler Kantonalbank, Aeschen, 4002 Basel
Medicus Mundi Schweiz, 4056 Basel
IBAN: CH40 0077 0016 0516 9903 5
BIC: BKBBCHBBXXX