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

What is it that global health organisations are seeking to decolonise?

From empowerment to power sharing – plan:g's quest for equitable global health partnerships

De Robert Moosbrugger et Bernhard Emmerich

Calls for decolonising global health have intensified in recent years. The Austrian NGO plan:g Partnership for Global Health has taken several steps to decolonise its work and to find new ways of communicating and engaging in equitable partnerships. Decolonising global health cooperation is however not without its challenges.

Meeting with beneficiaries, Zombo. Photo: © plan:g / Photo by Sierra Koder on Unsplash

The debate surrounding the movement to "decolonise global health" is currently being led by the scientific community in journals such as The Lancet, BMJ Global Health, or Global Health Research and Policy, as well as by students and practitioners of global health around the world. The debate is long overdue as global health, with its roots in colonial and tropical medicine continues to be permeated by colonial attitudes, structures and practices (Horton, 2021). Central to the debate are issues of equity and power asymmetry in global health (Finkel et al., 2022) and the necessary analysis of power embedded within organisations (Chaudhuri et al., 2021). The debate also calls for greater awareness of aid discourses and symbols that reinforce colonial attitudes and practices. These discussions are useful in guiding global health organisations in their efforts to decolonise their practices, as we will show here with the example of plan:g.

Decolonising symbols and narratives

plan:g Partnership for Global Health is a Catholic human rights organisation in the health sector of development cooperation with a regional focus on the Arab States and East and Sub-Saharan Africa. In 2013, plan:g launched a programmatic reorientation and critically questioned its own work in the health sector. This also meant a thorough examination of colonial attitudes and practices as well as power dynamics within the organisation.

The organisation plan:g was originally founded in 1958 as "Leprosy Relief Association Austria" (Aussätzigen-Hilfswerk Österreich). This name expressed a historical understanding of the organisation's work, rooted in global health's predecessors, colonial and tropical medicine. For many years, the organisation no longer felt this name was appropriate and in 2018 changed its name to plan:g Partnership for Global Health. This name change reflects a new understanding of the organisation’s work and was an important milestone in the effort to decolonise its symbols and narratives.

The organisation also started to rethink how to communicate with its key audiences (donors, non-financial supporters, decision makers). This meant, for example, critically questioning the type of images and photos plan:g uses in its communication and whether such photos could inadvertently convey stereotypes and colonial attitudes. The organisation decided to drastically reduce the use of photos of the beneficiaries, which are typically used to emotionally connect with donors. Instead, plan:g now aims to convey the complexity of its work and trigger broader support for positive change in the spirit of common cause communication. An example of this new visual communication is the use of a global health hidden object scene, which draws on the experience of plan:g's daily work and was designed by an artist.

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Global health hidden objects scene. Photo: © plan:g (https://en.weltgesundheit.org/)

Many discussions with people affected by leprosy and with partner organisations in the Global South prompted plan:g to reconsider its aid narrative. Aid narratives often simplify the complexities of global health and thus sometimes promote racist stereotypes that degrade others. They also tend to fall into the trap of "white savior" narratives and reflect the hubris of the West to reshape the rest of the world in its own image (Easterly, 2006). Decolonising global health narratives, therefore, meant for plan:g to adopt a different narrative that offers space for more complex explanations. Now plan:g understands and presents its work in global health as a human rights issue and not as “charity or saviorism” (Abimbola & Pai, 2020, p. 1628).

From empowerment to power sharing

In the English-speaking world the term “empowerment” has been applied since the late 1970s and by the mid-1980s the term began to be used in the development field. Originally, empowerment was conceptualized as a multifaceted process with individual and collective dimensions of power, and much of the work on empowerment initially drew on Paulo Freire's

(1970) Pedagogy of the Oppressed and his concept of “developing a critical consciousness”. Over the years, however, the concept has somehow become watered down and has drawn some criticism because in practice it often employs an individualizing notion of power that focuses on individual capacity and ignores social inequalities and power relations (Calvès, 2009). Despite justified criticism, empowerment is now rightly a cornerstone in the fight against poverty and social exclusion. However, it is necessary for international development organisations to take a more critical look at the different dimensions of power and to see where they themselves are involved in unequal power relations.

One of the most important areas in which international development organisations exercise power is obviously funding. “Money is power” as the saying goes. For plan:g, this meant the organisation had to search for a new model for funding decisions as part of its quest for equitable global health partnerships. This led the organisation to introduce a new Advisory Board to competently assesses project proposals according to the criteria of relevance, quality, project design, impact, partner quality and financing. The Advisory Board is made up of three women and three men, including two representatives from the Global South.

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Challenges for decolonising global health cooperation

Apart from a critical view regarding one`s own organisational history and role it played in the past the question remains how to deal with power disparities in the real life world. The way funding works always distinguishes between recipients and donors, in other words between the wealthy and the poor. There is simply no African development agency working on health or environmental issues in Europe. Leaders from the Global South stressed during the COP 27 summit that “donations” should be rephrased as “compensation”. This would indeed shift perceptions and furthermore legal responsibilities away from good will to accountabilities for colonial crimes and environmental degradation. However, the funding logic for small non state actors like plan:g remains the same. One way to mitigate the power imbalances is to actively engage stakeholders into programming and feedback loops.

Albeit many organisations claiming to do so, including state owned development agencies, this often just includes government actors and implementing organisations – hardly ever the beneficiaries themselves. There is no funding for preliminary needs assessments and the identification of homemade strategies to overcome issues. These involve a great deal of resources to capture the many voices and opinions in often challenging surroundings. The

dialogue is getting channelled through intermediaries at best, but this poses questions as to whether this approach is facilitating power inequalities, too. There is no shortage of stories about corruption in aid, linked to all actors along the process. The only practicable solution is to conduct an impact analysis after the intervention has been concluded. Although this might seem as way to reverse the logic of a beneficiary driven development process, it`s a lot easier to secure funding for and provides for valuable insights regarding the efficiency of the programmes in question and helps to adjust future health interventions.

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Similar to the problems stated above are the challenges for advocacy. If conducted true to the word, it needs to be based solely on the demands of those who wish for change. UNICEF embraced the rights-based approach, arguing that child rights need to be respected, regardless whether children actually did ask for the proposed change (UNICEF, 2016). Taking into account that children globally just don't have the means to claim their rights, it does make perfect sense. Accordingly, this could be the way forward in global health, too. However, the question remains which of the many facets of health are prioritized and in which sector there is a credible chance to persuade actors to change their policies. This poses more questions that are entangled with agenda setting: How do you advocate with authoritarian governments that might benefit in regards to holding on to power? How to engage with powerful actors like the pharmaceutical producers that are in the end dependent on maximizing their revenue?

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Conclusion

It is clearly crucial for organisations like plan:g to engage in a process of critical self-evaluation, but this does not automatically lead to better ways of building equitable relationships in global health cooperation. At worst, it could be seen as a sort of whitewashing one's own image. The stony road ahead lacks a "dominant design" and requires a pragmatic strategy including the dialogue with as many actors in the Global South as possible (Oti & Ncayiyana, 2021). This

approach is anything but straightforward, but necessary for any meaningful way to escape the colonial trap. Empowerment and power sharing are therefore not mutually excluding concepts but rather attempts to manifest global learning and inclusiveness.

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