Indian Journal of Surgery (April 2022) 84(2):259–261
https://doi.org/10.1007/s12262-022-03330-6

EDITORIAL

Post-decolonisation: Global Health and Global Surgery's Coming of Age

Bhavna Chawla[1] · Judith Lindert[2] · Dhananjaya Sharma[3]

Received: 23 December 2021 / Accepted: 9 February 2022 / Published online: 19 February 2022

Global Health and Global Surgery (GH&GS) are vast disciplines incorporating much more than Public Health for the underprivileged. Worldwide mortality from lack of access to safe and affordable surgical care when needed was estimated to be 18.6 million in 2010, which was ~ 5 times more than the combined mortality from HIV, tuberculosis, and malaria [1]. Realisation of its magnitude and challenges has made GH&GS a very appealing discipline, and many outreach programs from countries, universities, and non-government organisations from the Global North provide help to > 1/3rd of the world's population which needs such assistance, including training and capacity building for the local health care workers (HCWs).

GH&GS, despite its best intentions, is not known to be without its colonial overtones and challenges [2]. A recent development is the ardent call to 'decolonise' GH&GS. This has been prompted by a flurry of GH&GS outreach programs with many inherent flaws. These include centralisation of all organisational powers in Global North, exclusion of local experts from production/interpretation of knowledge meant for their benefit, marginalisation of knowledge already available at the grass-roots, the disconnect between actual needs of beneficiaries and the proposals from the Global North, lack of inclusivity and diversity in the organisational structures, lack of transparency of on-ground work, and the perception of their colonial ambitions to protect an imperial hegemony [3, 4]. Such lack of diverse perspectives from grass-root results in loss of previously learned lessons and important information on uptake or implementation challenges. Additionally, such top-down unsuitable policies fail to get the support of broader communities, who could have played important advocacy, network, legitimacy, and support functions [5]. Colonialism's most fundamental legacy in global health is a political economy that prioritises financial sustainability over access to health care. These flawed models for health systems, created in the Global North, promote accountability to money over accountability to society, and prioritise 'wealth creation over health creation' [6]. Current GH&GS efforts have been found lacking in many ways, and the call for their decolonisation has been strongly endorsed by several prominent authors [7]. Finally, providing GH&GS help without injuring the self-esteem and honour of the recipients is an art which must be learned and practiced by all the volunteers [8]. Failure to do so is another reason for resentment culminating in a call for decolonising GH&GS.

Recently, the call for decolonisation has become a shrill chorus with the use of words such as 'parasitic helicopter/parachute research' and 'epistemic injustice' [9, 10]. This phenomenon is even more rampant in popular social media, with its easier alternate pathway of communication for those working at grass-roots level. However, such a din has the inevitable risk of losing the signal, especially the perspective and contextual goals, amidst the noise.

All this has created quite an upheaval and resulted in plenty of tremors in the field of GH&GS. The jolt has shaken up the system, and these fault lines are being repaired by increased sensitisation to these issues and necessary rectification. This includes better focus on development of local Human Resources, increase in proportion, and diversity of local trained staff across every domain from healthcare to logistics to administration. Additionally, several explicit guidelines and constructive strategies, including what to

✉ Dhananjaya Sharma
dhanshar@gmail.com

Bhavna Chawla
bhavna_lc@yahoo.com

Judith Lindert
judith.lindert@uksh.de

[1] Médecins Sans Frontières Amsterdam, Holland and International Committee of Red Cross Geneva, Geneva, Switzerland

[2] Department of Paediatric Surgery, University Lübeck, Ratzeburger Alle 160, 23562 Lubeck, Germany

[3] Department of Surgery, NSCB Government Medical College, Jabalpur, MP, India 482003

do and what not to do — for the journals and journal editors, collaborating research institutions and funders — have been developed to ensure a truly equitable non-hierarchical partnership, including authorship credits, in North–South GH&GS collaborations [11–16]. For Global North volunteers, a common thread running through these is reaffirmation of age-old human values such as working in harmony while complementing the HCWs, inculcating mutual trust and respect, learning the local needs by learning the local disease patterns, and making sure to diagnose common problems first, sensitivity, respect, and acceptance of local customs and cultures, learning to negotiate the consent (especially for surgeries like amputations, hysterectomies and stoma formations) with the next of kin or caretakers with the guidance of local HCWs, owning up to responsibility and a willingness to learn. These also include yardsticks for a healthy equitable partnership, which are sustainable programs for local capacity building, empowering the host HCWs and the community with their defined needs, bidirectional input and mutual learning, and compliance with all applicable laws, ethical standards, and code of conduct, including for authorship.

In spite of multitude of these developments, accusations of more rhetoric than action have been made and skepticism persists about viability and sustenance of GH&GS once colonisation recedes [17]. Reasons for such cynicism are multifactorial and include complete spectrum of power being centred in individuals and agencies in Global North who are likely to resist any reforms in an attempt to stay relevant in these changing times and may hide behind evasive token superficial cosmetic changes.

We believe that most volunteers in the field of GH&GS do so out of a philosophy of *noblesse oblige* and are expected to conduct themselves gracefully without being patronising or condescending. However, the persisting supercilious arrogance of some do-gooders can be appalling. In a recent international meeting, one of the authors (DS) was shocked to hear one luminary of the GH&GS field refer, twice, to his work as 'white man's burden' (the alleged duty of white colonisers to care for non-white indigenous colonised subjects) in a hall full of delegates from African continent. The audience was very gracious and ignored his boorish comments.

There is no longer any place for such a colonial mind-set. Astonishingly, this advice applies equally to the HCWs in the Global South. Glamour-stuck, quite a few of them are known to shun assistance offered by their capable Global South colleagues (a South-South partnership with much simpler logistics) and prefer to wait for outreach programs of elite universities of Global North as their association is considered more prestigious. Similarly, many authors from the Global South keep submitting their papers to elite journals where there is little chance of their acceptance, rather than submitting to local journals (and thus strengthening their content) where they have good chances of publication [18]. Ideally, the local authors should write about the local issue from a local perspective for local readers [19]. Other steps to be taken by HCWs in the Global South include their willingness to move out of their comfort zone, freeing themselves from dependency, strengthening local research capacity, and seizing the opportunity to take responsibility for their own destiny and development [15, 20]. A recent success story is that of Chidiebere Sunday Ibe, 25, a Medical Illustrator and aspiring Neurosurgeon from Nigeria, whose illustrations of Black patients, children, and babies have gone viral (https://twitter.com/ebereillustrate).

We would also like to point out that epistemic injustice and epistemic positioning are, unfortunately, common in general society as exemplified by recent Global Vaccine inequity in the face of COVID-19 [21]. And GH&GS is no exception. Perhaps any injustice here is seen as more grievous because 'equity in health' is the *raison d'être* of GH&GS and the same standards of 'equity' are expected across the board in this field. It is disingenuous to claim that none of the Global North workers are party to deliberate/unintentional patronising suboptimal sharing of power and academic credit with the local HCWs from Global South. However, in this strident debate, we feel, some important points are being missed: Are we not guilty of indirect accusations against 'all' the GH&GS workers from Global North, dismissing all their efforts and demonising them by painting them with the same brush? Can we doubt and question the intent of various organisations who reach out to make available basic healthcare, vaccines, food, potable water, education, or basic surgeries in various places where needed? Is not that what global equity is all about? Do majority of GH&GS workers from Global North, whether seniors or youngsters, not volunteer their services with altruism in their hearts? Most volunteers take a leap of faith out of their comfort zones to go to unknown lands with unknown language and culture and unfamiliar living conditions and food. Their experiences are quite humbling; yet many do so again and again for the sheer passion of the cause of equitable healthcare.

Finally, in our humble opinion, in addition to assisting/enabling the underprivileged in Global South, the ultimate aim of GH&GS is to make sure the recipients become self-reliant and stop needing such help. If this is remembered, along with the current degree of sensitisation, perhaps it will make things easier all around — including appropriate sharing of academic credit and power.

It has been argued for long that terms like 'colonialism' are not helpful as they are too easy to dismiss as extreme and ideological [3]. It is time for GH&GS to shed its vestiges of past by *really* including local experts rather than just tick the *diversity* box. We suggest the phrase '*Coming of age*' for the new transformed sensitised GH&GS. HCWs from both Global North and Global South must lose their colonial and post-colonial mind-sets respectively and fully embrace the change so that they truly become the two sides

of the same GH&GS coin, and complement each other to work in sync towards the same milestone — accessible healthcare for all. The problems we face together are well known, the process of reform has begun, the roadmap for decolonisation is established, and all that remains is for HCWs worldwide to 'walk the talk' — together, hand in hand.

Declarations

Conflict of Interest The authors declare no competing interests.

References

1. Meara JG, Leather AJ, Hagander L et al (2015) Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. Lancet 386(9993):569–624. https://doi.org/10.1016/S0140-6736(15)60160-X
2. Welling DR, Ryan JM, Burris DG, Rich NM (2010) Seven sins of humanitarian medicine. World J Surg 34(3):466–470. https://doi.org/10.1007/s00268-009-0373-z
3. Horton R (2013) Is global health neocolonialist? The Lancet 382(9906):1690. https://doi.org/10.1016/s0140-6736(13)62379
4. Abimbola S (2021) The uses of knowledge in global health. BMJ Glob Health 6(4):e005802. https://doi.org/10.1136/bmjgh-2021-005802
5. Bertram K. Thought leadership suffers from insider-outsider divide in global health. https://katribertram.wordpress.com/2020/07/25/thought-leadership-suffers-from-insider-outsider-divide-in-global-health/. Accessed on 16 Dec 2021.
6. Yerramilli P. To decolonize Global Health, we must examine the global political economy. https://www.thinkglobalhealth.org/article/decolonize-global-health-we-must-examine-global-political-economy. Accessed on 20 Dec 2021.
7. Lincoln M (2021) Global health is dead; long live global health! Critiques of the field and its future. BMJ Glob Health 6(7):e006648. https://doi.org/10.1136/bmjgh-2021-006648
8. Schein M (2010) Seven sins of humanitarian medicine. World J Surg 34(3):471–472. https://doi.org/10.1007/s00268-009-0385-8
9. Health TLG (2018) Closing the door on parachutes and parasites. Lancet Glob Health 6(6):e593. https://doi.org/10.1016/S2214-109X(18)30239-0
10. Bhakuni H, Abimbola S (2021) Epistemic injustice in academic global health. Lancet Glob Health 9(10):e1465–e1470. https://doi.org/10.1016/S2214-109X(21)00301-6
11. Marks IH, Thomas H, Bakhet M, Fitzgerald E (2019) Medical equipment donation in low-resource settings: a review of the literature and guidelines for surgery and anaesthesia in low-income and middle-income countries. BMJ Glob Health 4(5):e001785. https://doi.org/10.1136/bmjgh-2019-001785
12. Pai M. 10 Fixes for global health consulting malpractice. Global Health Now August 12, 2019. https://www.globalhealthnow.org/2019-08/10-fixes-global-health-consulting-malpractice. Accessed on 10 Nov 2021.
13. Khan M, Abimbola S, Aloudat T, Capobianco E, Hawkes S, Rahman-Shepherd A (2021) Decolonising global health in 2021: a roadmap to move from rhetoric to reform. BMJ Glob Health 6(3):e005604. https://doi.org/10.1136/bmjgh-2021-005604
14. Haelewaters D, Hofmann TA, Romero-Olivares AL (2021) Ten simple rules for Global North researchers to stop perpetuating helicopter research in the Global South. PLoS Comput Biol 17(8):e1009277. https://doi.org/10.1371/journal.pcbi.1009277
15. Rasheed MA (2021) Navigating the violent process of decolonisation in global health research: a guideline. Lancet Glob Health 9(12):e1640–e1641. https://doi.org/10.1016/S2214-109X(21)00440-X
16. Morton B, Vercueil A, Masekela R, Heinz E, Reimer L, Saleh S, Kalinga C, Seekles M, Biccard B, Chakaya J, Abimbola S, Obasi A, Oriyo N. Consensus statement on measures to promote equitable authorship in the publication of research from international partnerships. Anaesthesia. 2021. https://doi.org/10.1111/anae.15597
17. Abimbola S, Pai M (2020) Will global health survive its decolonisation? Lancet 396(10263):1627–1628. https://doi.org/10.1016/S0140-6736(20)32417-X
18. Sharma D (2021) A call for reforms in global health publications. Lancet Glob Health 9(7):e901–e902. https://doi.org/10.1016/S2214-109X(21)00145-5
19. Abimbola S (2019) The foreign gaze: authorship in academic global health. BMJ Glob Health 4(5):e002068. https://doi.org/10.1136/bmjgh-2019-002068.
20. Masekela R, Mortimer K, Aluoch J, Ozoh OB. Building research capacity to correct global health's wrongs. Lancet Glob Health. 2021:S2214–109X(21)00491–5. https://doi.org/10.1016/S2214-109X(21)00491-5.
21. Bacevic J. Epistemic injustice and epistemic positioning: towards an intersectional political economy. Current Sociology November 25, 2021. https://doi.org/10.1177/00113921211057609.