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## Symposium Articles

# Decolonial Framings in Global Health Law: Redressing Colonial Legacies for a Just and Equitable Future

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**Abstract**

Colonialism has produced the global health system, and decoloniality must inform global health law. This article considers the foundational impact of colonialism on the global health system and advocates for adopting decoloniality as a crucial framework to reshape global health law. Through a historical lens, it examines how European colonialism established power dynamics and structures that continue to influence contemporary global health governance. This article calls for overcoming enduring challenges by emphasizing the urgency of dismantling outdated and unjust systems that perpetuate health inequities and hinder effective interventions. It argues for a paradigm shift toward epistemically inclusive, ethical, and equitable practices, emphasizing the active participation of marginalized communities in health policymaking. By addressing the root causes of health disparities and decoupling health systems from racial capitalism, a decolonial approach promises a more just and effective future for global health law.

**Keywords:** ethics; equity; race; global health

## Introduction

Despite efforts to realize global health with justice,[1] international relations have often been shaped by the colonial matrix of power (CMP),[2] a concept developed by scholars like Walter D. Mignolo to describe how European colonialism from the 16th to the early 20th century established the foundations of the current neoliberal global system. This historical framework underpins calls to dismantle outdated and unjust global systems, such as the global financial institutions created during the Bretton Woods Conference in 1944. Barbadian Prime Minister Mia Mottley argues that institutions like the IMF and the World Bank, designed for a world with 44 member states, are ill-suited for today's 195 independent states — and perpetuate an oppressive debt structure for low-income countries.[3] Similarly, global health governance, established in its current form with the creation of the World Health Organization (WHO) in 1948, evolved from colonial medicine through international health. The governance ecosystem of bilateral donors, philanthropic organizations, NGOs, and multilateral organizations is rooted in political and historical relationships formed during colonial times. The 1885 Berlin Conference, where colonial powers partitioned Africa, still influences 21st-century donor relationships, scientific exchanges, and research partnerships between European universities and African institutions in former colonies.

Racial capitalism, a theory placing racial hierarchies at the core of capitalist systems,[4] underpins neocolonial dynamics and influences global functions, including in global health governance. Despite advocating cosmopolitan rights-based norms, global health governance mainly serves to protect wealthy, primarily Global North countries from communicable diseases.[5] This is evident in the distribution of resources for global public goods, participation dynamics in health policy development, and international agreements on access to essential medicines. COVID-19 vaccine distribution inequities revealed that even in international crises, certain nations' interests are prioritized over others.[6] These inequities reinforce a racial hierarchy where nations with predominantly Black and Brown populations are disproportionately affected compared to those with white-majority populations. The structural disparities within global health are evident in the mechanisms of collaboration, coordination, and governance across international borders. These structures are profoundly influenced by race, gender, and sexual orientation, systematically privileging certain dominant groups over others. Historically entrenched, these inequities often require disruptive events to be brought into the public consciousness and critically examined. This article examines the foundational impact of colonialism on the global health system, recognizing the urgent need to address these issues and decolonize global health systems as essential for creating an equitable and inclusive global health law landscape.

## Persisting Colonial Legacies Within Global Public Health

Contemporary global health law has progressively developed critical instruments such as the International Health Regulations (IHR) that attempt to create an international legal standard for all states. Still, even the IHR is rooted in the 19th-century International

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Sanitary Conventions, which themselves reflect the enduring colonial influences and priorities of that era, designed more to protect the interests of colonial powers than to address global health in a more equitable manner.[7] The direct importation of colonial laws continues to impact health governance, globally and across many formerly colonized countries. At the national level, government authorities for handling pandemic responses often rely on outdated colonial public health legislation.[8]

Colonial legacies have also impacted key principles that advance global health law such as the principle of participation. Colonial systems of governance have denied many communities in formerly colonized countries an opportunity to participate in key decisions that affected them. Mulumba and colleagues undertook a case study of Uganda to illustrate how decades of brutal colonial law had eroded indigenous values and diminished beliefs and practices. The legal and health systems introduced under colonial rule continue to influence present-day decision making and accountability of the state on matters that affect the health of communities in Uganda.[9] Decolonizing health governance is thus essential for ensuring community participation in health systems in post-colonial countries.[10]

Some areas of global health law, such as Sexual and Reproductive Health and Rights (SRHR), continue to be obscured by their colonial origins. Persistent discussions around SRHR dichotomies and binaries — such as traditional vs. modern, relativism vs. universalism, pro-life vs. pro-choice, and socially (and sexually) conservative vs. liberal and permissive — have not spared the overarching colonial, neocolonial, and often Anglo-American influences that pervade the entire framework of both historical and contemporary SRHR work.[11]

Decoloniality calls for a paradigm shift — from Eurocentric models to inclusive practices that recognize the knowledge, agency, and rights of local populations and marginalized communities.[12]

## Towards More Just Systems in Global Health Law

Global health law, alongside other dimensions of global health such as policy making, research, and advocacy, can break the strong ties that have historically reinforced the objectives and priorities of dominant stakeholders. The institutions of global health governance are entangled with the standards and practices that perpetuate settler colonial knowledge.[13] This has a bearing on how good health is defined, governed, funded, and pursued. Building more just systems of global health law requires confronting foundational flaws in the field and rectifying systematic exclusion and marginalization. This can take the form of three interlocking practices: Understanding and unlearning structural racism; fostering and integrating epistemic justice through indigenous and non-biomedical knowledge; and making an urgent and unconditional shift to health as a universal human right.

### *Understanding and Unlearning Structural Racism*

Global health law must confront the implications of "race" on people's health. Race is not a biological fact; it can neither be defined nor defended phenotypically, as most genetic variation is found within members of the same race.[14] Race is a cultural construct (about how human variation is structured) that has biological consequences.[15] We need disaggregated data to understand and rectify health inequities and structural discrimination. On one hand, such data on caste, ethnicity, and race continue to be patchy and of poor quality. On the other hand, such data can be used to create prejudice and manipulate policies to the detriment of minorities. We need to seriously consider the role of global health law in regulating the surveillance, collection, use, and dissemination of such data.[16]

Further, racial categories are often employed within institutions where health law, policy, and programs are designed. Even where these categories are not emanating from colonial, racist, or eugenicist motivations, they nevertheless perpetuate a hierarchization and stratification of people based on myriad justifications of 'improvement' and 'growth' that continue to be led by erstwhile colonizers and Global North countries.[17] Structural reform would require us to commit to undoing racialized differences in health by paying attention in global health law to the conditions and histories that "expose persons and communities of color to a life of increased stress, pollution, and poor health care."[18]

### *Applying Epistemic Justice*

The neglect and destruction of Indigenous and non-biomedical care paradigms are rooted in colonialism. With health policy reflecting the interests of dominant groups,[19] this status quo perpetuates epistemic violence, silencing native approaches to wellbeing and care.[20] Consequently, marginalized populations have little role in shaping global health knowledge and solutions. To counter this, a decolonial framing of global health law can reclaim and integrate diverse narratives and knowledge, fostering a more nuanced, fair, and widely accepted understanding of global health.

Mignolo asserts that the goal of decoloniality is to delink from foreign western control and hegemony in order to re-exist and relink with indigenous modes of existence and engagement.[21] There is an opportunity through decoloniality to redeem emerging approaches such as "One Health," an integrated approach that aims to sustainably balance and optimize the health of people, animals, and ecosystems.[22] This sense of interconnected living — transcending the boundaries of human, non-human, environment, and indeed the cosmos — is a core tenet of many Indigenous healing systems. For instance, the Mayan people possessed a rich understanding of medicinal plants, emphasizing the importance of adapting to and living in harmony with one's environment.[23] Another example of expanding the epistemic aperture is the use of the African humanist philosophy of Ubuntu — meaning "I am because we are" — in public health policy.[24] This approach emphasizes individual personhood through community relationships, contrasting with colonial legacies and Western ideals of self-interest and individuality. Applying epistemic justice in global health law will require integrating, expanding, and strengthening the conceptualization of global health law, not just placating local cultures or customizing interventions.

### *Ensuring the "Right to Health"*

The WHO plays a central role in global health dynamics, aligning with decolonial and equitable values by implementing the right to health in global health governance. Foundational in governance, the WHO Constitution asserts that health is a fundamental right for everyone, regardless of race, religion, or socio-economic status.[25] However, WHO governance often maintains colonial structures and geopolitical realities through its financing, leadership preferences, and policy influences. Despite this, WHO is expected to uphold human rights to advance health justice.[26]

Universal Health Coverage (UHC) is a practical expression of the right to health,[27] and more countries commit to UHC each year under the Sustainable Development Goals. Civil society groups have been pivotal in seeking to decolonize global mechanisms to deliver the right to health, as exemplified by UHC2030, which

coordinates efforts by WHO, the World Bank, and others.[28] These groups hold governments accountable for financing commitments, emphasizing the importance of community involvement in decision-making and ensuring transparency. Engaging civil society at all levels will be crucial for effective and equitable global health governance that realizes the right to health.

## Conclusion

Advancing global health law requires adopting decoloniality as a fundamental framework. This shift is essential for addressing historical inequities, fostering inclusive practices, and ensuring equitable participation from marginalized communities. To achieve effective and reliable international cooperation, we must critically assess global governance structures to realize adequate inclusion of the world. This is not merely a corrective measure but a transformative pursuit.

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