Decolonization Through Decolonial Reforming

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The need for reform of the global health system is openly on the table. Many stakeholders agree that the WHO has not been able to adequately address the political and social problems, global health emergencies triggered or exacerbated by epidemics and pandemics, malnutrition, and access to clean water in recent years. Against this backdrop, there is a widespread call for more equity and solidarity in the global health system.

In response to the Covid-19 pandemic, two independent reform proposals are currently being discussed within the WHO: the reform of the International Health Regulations (IHR) and the resolution of a new pandemic treaty. The IHR reform pursues the goal of "strengthening WHO preparedness and response to health emergencies" by prioritizing equity, fortifying the IHR, and improving WHO's financing. The draft for a pandemic treaty also recognizes the failure of the global health system, particularly in light of the Covid-19 pandemic. As guiding principles and rights, the draft includes the respect for human rights and the right to health, equity, transparency, solidarity, accountability, and inclusiveness (Art. 2 and 3 of the proposal). Thus, the shared objectives of a potential pandemic treaty and the direction of IHR reform are clearly outlined.

Most of the proposals concerning the reform of the WHO deal with the possible goals and outcomes of such a reform. However, it is just as important to consider how such a reform should be carried out so that the ambitious goals are not compromised by the implementation process itself.

From Colonial Health to Equitable Health

Many criticize the fact that the WHO has never freed itself from colonial patterns of knowledge production, participation and problem-solving. They contend that the WHO, contrary to its own claim, does not realize justice and the equal right to health for all. Instead, it perpetuates global and post-colonial inequalities. The international system of states emerged at a time when a large part of the world was under the violent foreign rule of European colonial empires. Since the beginning of international organizations, global decision-making has been dominated by the interests of rich countries – especially those of the Global North. These structures of inequality are still reflected in the international system today, reinforcing the supremacy of powerful states, especially over those of the Global South, and maintaining a state-centric focus that primarily obligates and entitles states. The history of global health also has its origins in colonial medicine, tropical medicine, missionary medicine, and international health. These fields were less concerned with a universal right to health

for all people and more focused on governing and dominating colonial subalterns, exploitation, oppression, and securing world trade and shipping.

A decolonial reform process must strive to overcome these goals. This is already being acknowledged, for example, in the preamble to the Zero Draft for the Pandemic Treaty, as well as in the latest Intergovernmental Negotiation Body (INB) proposal and in many suggestions for reform. "To decolonize 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, glaringly, in how global health organizations operate, who runs them, where they are located, who holds the purse strings, who sets the agenda, and whose views, histories, and knowledge are taken seriously", Abimbola and Pai demand. However, a decolonial reform process must also be designed differently, because for the results of the process to be fundamentally different, the reform processes themselves must change. To achieve greater equity in the global health system, the process itself must be equitable.

This requires a fundamental change in two respects: an equitable reforming process must involve many different actors to enable a diversity of perspectives. To leverage this diversity of actors and perspectives, other modes of operation are also required. The participation and working methods must reveal, reflect, and actively combat the underlying power relations and hierarchies.

Representation and Participation for a broader diversity of perspectives

The international state system is state-centered, entrenched by political-economic structures, and oriented towards the interests of powerful states and their societies. A decolonial reform process must ensure the representation and participation of many different actors in order to enable a diversity of perspectives. Several states are jointly calling for an "all-of-government and all-of-society approach" – but the implementation of such an approach must consider the actual power hierarchies and enable broad participation.

One aspect of this approach is the equal participation of all states. What sounds like a matter of fact is rarely a reality at the international level and has not yet been realized in current reform processes. Instead of backroom discussions between representatives of powerful states, all states should genuinely have the opportunity to participate in the reform process on an equal footing at all times. Because "[p]rocess shapes outcomes, in first offering a level-playing field for all countries before even formal negotiations begin". This corresponds to Art. 11, 59, 60 of the WHO Constitution.

However, this broad participation is also necessary beyond governmental actors. The normative starting point for the integration of non-state actors is Art. 71 of the WHO Constitution, which enables the WHO to "consult and co-operate with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental". In

addition, Art. 2 (b) provides for cooperation between the WHO and “professional groups and such other organizations as may be deemed appropriate”. Later, it states that the WHO should “take all necessary action to attain the objective of the Organization” (Art. 2 (v) WHO-Constitution). In addition to normative arguments, the purpose and mission of the WHO to promote the health of all people can also be used as an argument for the involvement of non-state actors.

Effective health regulation that benefits all people and realizes a universal right to health (equity) requires the inclusion of diverse perspectives in the reform process. Such a diversity of perspectives provides sufficient knowledge about complex global contexts and local specifics, which is necessary for effective regulation. This is also reflected in the guidelines for IHR reform: the IHR Review Committee should bring together IHR experts and other experts “on the basis of the principles of equitable geographical representation, gender balance, a balance of experts from developed and developing countries, representation of a diversity of scientific opinion, approaches and practical experience in various parts of the world, and an appropriate interdisciplinary balance” (IHR 2005, Part IX, Chapter III).

Civil society organizations have fought in recent decades to strengthen public interest in the international arena and advocated the interests of those who are underrepresented there: poor people, (formerly) colonized people, the environment, and the climate. In a state-centered and power-based international system, these organizations can bolster weak interests. Many civil society organizations have long campaigned for the realization of the right to justice in the global health system and the right to health, and have built up extensive expertise in this area. By advocating for general interests, they can counteract the growing influence of private profit-oriented actors in the health sector (such as transnational pharmaceutical companies). As NGOs can also be elite-driven projects, it is important to involve a larger number of different NGOs and to include and listen to civil society actors from all parts of the world.

In recent years, however, those who are mostly affected by unsolved problems and regulations have raised their voices. One example of such participation by affected persons is the success story of Via Campesina, an international initiative founded in 1993 by small-scale farmers. Through their long struggle, they achieved international recognition in the area of food and agriculture. The organization has been involved in key political processes such as those in the Food and Agriculture Organization of the UN, the Human Rights Council, and World Intellectual Property Organization, and was involved in the drafting of the United Nations Declaration on the Rights of Peasants and Other People Living in Rural Areas, adopted in 2018. Such forms of participation by affected individuals are not only conceivable and legally possible but also functionally beneficial in global health.

Not all perspectives are equally valuable

The “who” also includes the “who-not”. In order to address the functional argument for the inclusion of non-state actors, it is also essential to set boundaries on the involvement of private entities. This applies to corporate private actors (e.g.

pharmaceutical companies) as well as to philanthropic organizations such as the Bill and Melinda Gates Foundation, public-private partnerships, or consulting firms. In July 2022, Nicoletta Dentico and Ashka Naik warned that the expansion of the stakeholder list for the INB could be a "blank check for the entry of still-more vested interests". At that time, the "proposed modalities for engagement for relevant stakeholders do not in fact propose any safeguards against corporate political interference". Many of the actors proposed for participation in the reform process are transnational companies with "direct corporate interests". Environmental health NGOs, on the other hand, are hardly involved, and global environmental advocacy groups are not included at all, despite their efforts. This criticism remains largely valid today, as corporate actors continue to be included in the latest "modalities of engagement for relevant stakeholders". A central problem is that the negotiations on the question of which non-state actors should be involved take place in private, without media publicity and "without much possibility for intervention by existing [civil society organizations]". True transparency, therefore, requires an open discussion about who should be recognized as a stakeholder. The INB must develop and apply "convincing and transparent criteria" for the participation of non-state actor groups. These must include the selection itself, but also policies on the disclosure of conflicts of interest and consultations with private parties. Transparency must be more than just a neoliberal buzzword; it must be grounded in universally applicable rules to control corporate interests. The aim must be to push private interests and market logic out of the health sector as far as possible.

Need for procedures for cooperation and transparency

To leverage the diversity of perspectives among stakeholders, alternative working methods that acknowledge the hierarchies of power, influence, resources and knowledge of the various actors are necessary. A reform process should be developed and implemented collaboratively. Platforms for exchange, regional cooperation and working groups, as well as North-South cooperation, can ensure good cooperation between the very different stakeholders. The cooperation and participation of different actors must be actively promoted and supported. A new form of cooperation between countries of the Global North and South can emerge if the former explicitly embrace decolonial and anti-racist demands aimed at solidarity and actively support them in the reform process.

Reform processes at an international level are often planned in the backrooms of world politics. However, a robust participatory reform process requires transparency not only about the actors involved but also about the process itself. As drafts are the basis for further discussions, all proposals must find equal consideration in the drafts. As for informal sessions, there is disagreement concerning its impact on transparency. While they facilitate informal exchanges among all states, states with smaller delegations have fewer opportunities to engage or participate in parallel sessions. Thus, there is a need to develop formats which allow to join forces for smaller, less powerful countries while still ensuring transparency for all negotiators.

For a collaboration that is cognizant of power hierarchies between different stakeholder groups and to ensure genuine transparency, it is crucial for the structures to recognize and reflect on the actual dangers posed by the politics of interest of the most powerful and a lack of transparency. Such openly reflective structures can prevent inclusiveness, collaboration, and transparency from becoming mere tropes and guide the processes.

Decolonial reform processes require a scientific basis and a cross-sectoral approach

A reform process should be guided and accompanied by research-based and interdisciplinary approaches. It should consider and incorporate scientific findings from various disciplines, such as medicine, biology and epidemiology, computer and data sciences, law, political science, sociology, anthropology, and ethics. Only through a collective effort and reliance on scientific findings, it will be possible to comprehensively analyse problems and find solutions.

Reform processes at the international level are often segmented and unconnected, partly due to their complexity. A reform process should adopt a cross-sectoral approach. It should not be confined to health in the narrower sense, but should encompass other sectors as well: Regulations and misalignments in areas such as food, agriculture, or environment/climate protection, and even trade or property law, can significantly influence the global health system and the realization of the universal right to health.

Conclusion: Decolonial reform needs new processes

There will be no easy solutions and no simple techniques for the upcoming reforms. The result will not be perfect, but it could at least be as good as possible. However, the decolonization of the global health system is a major challenge, especially against the backdrop of persistent hierarchies and inequalities within the international community of states, within and between societies and global crises. The massive inequalities with regard to the realization of the right to health, which also reflect colonial continuities, come to the fore in the form of fundamental conflicts of interest and conflicts in the reform of the WHO.

Within the framework of the reform process, these conflicts of interest can only be addressed with procedural requirements that mediate between unequal positions and thereby balance power imbalances. The reform of international health law first requires the development of an international health dispute law. This requires participatory structures and procedures that enable the broad and equal participation of different actors. The reform structures should reflect the underlying inequalities and hierarchies and, if possible, balance them out. However, they should also leave room for the transparent and equal negotiation of conflicting interests and conflicts. Reforms need structures that do not undermine their own goals but rather pave the

way. A process of decolonization must anticipate its outcome within the process: The process itself must be decolonial, provisionally establishing an equality that has yet to be realized in the long term.