

CAESAR
ATUIRE &
SUSAN BULL

COVID-19 Heightens the Imperative to Decolonize Global Health Research

Abstract: The COVID-19 pandemic has both highlighted and exacerbated global health inequities, leading to calls for responses to COVID to promote social justice and ensure that no one is left behind. One key lesson to be learnt from the pandemic is the critical importance of decolonizing global health and global health research so that African countries are better placed to address pandemic challenges in contextually relevant ways. This paper argues that to be successful, programmes of decolonization in complex global health landscapes require a complex three-dimensional approach. Drawing on the broader discourse of political decolonization that has been going on in the African context for over a century, we present a model for unpacking the complex task of decolonization. Our approach suggests a three-dimensional approach which encompasses hegemonic; epistemic; and commitmental elements.

Keywords: *Africa; data-sharing, decolonization; global health justice; health research*

Introduction:

The COVID-19 pandemic has peaked in different regions of the world at different times. What started out in China and South Korea soon became an emergency in Italy, Spain, France and the UK. Then came the turn of the Americas, with the USA, Brazil and Mexico recording high numbers of deaths and infections. South East Asia, particularly India, also experienced high numbers in June 2020, two months after the peak in Italy and Spain. Even though the presence of the virus was detected in Africa as early as February, the overall spread of COVID-19 on the African continent has been slower (WHO Regional Office for Africa, 2020). However, as of 5th July 2020, reported COVID-19 cases across the African continent quadrupled in a period of four weeks, a growth rate similar to that of other continents (Africa CDC, 2020).

Given the initial slow spread of the virus, African countries seemed to have a comparative advantage and the opportunity to review experiences in other

regions. The measures taken by various African governments to curb the spread of the virus, even though underreported in mainstream Western media outlets (Hirsch, 2020), seemed to be yielding good results. However, the increase in the spread of the virus in the second half of the month of June, showed that African government responses may also be caving in under the aggressive nature of COVID-19.

The initial measures taken by African governments to limit the spread of the virus mirrored actions that had been taken in other parts of the world: closure of borders; partial lockdowns of cities; contact tracing and isolation; testing; social distancing; handwashing; use of face masks in public spaces; ramping up of healthcare systems through purchasing ventilators and PPEs; research into treatments and vaccines. Each of these measures applied in the African context come with a peculiar set of problems. Border closures left Africans stranded abroad, penniless, and unable to return home. Lockdowns had to be lifted in many countries after a few weeks because they were threatening the very livelihood of the poorest members of communities. Contact tracing and isolation remains a challenge for countries in which homes do not have addresses and where environments like markets and public transportation are crowded. Testing on a wide-scale is virtually impossible when countries do not have the facilities, resources and qualified personnel to test large portions of the population. Social distancing is impossible for people who live in crowded urban spaces or in communities where access to basic needs like water and toilets are shared by large numbers of people. Handwashing and the use of clean face masks require access to sanitary conditions that are not available to all. Many African governments have very limited capacity to provide critical care facilities, or to repurpose existing facilities (such as conference centres) to rapidly expand capacity, as undertaken in multiple high-income settings.

As the number of infected persons on the continent continues to rise, African governments are grappling with the challenge of finding sustainable context-based solutions to the COVID-19 pandemic. Given the evidence that Africa cannot import, wholesale, solutions that have been applied elsewhere outside the continent, academics and African leaders are advocating for home-grown solutions (Glassman et al., 2020). The importance of developing and implementing contextually relevant solutions highlights the need for effective decolonization, a topic that was gaining traction in global health prior to the pandemic.

A notable characteristic of the COVID-19 pandemic is the way it exposes inequalities and systemic fragilities. The importance of promoting social

justice in global health responses to COVID-19 has been highlighted, with specific attention being drawn to the devastating impact of COVID-19 on low income and marginalised communities (Ivers and Walton, 2020). The exposure of inequalities and systemic fragilities is also evident at a global level. Global health is inherently a complex field of social, political, economic, and scientific relationships in which various stakeholders have unequal power. A range of powerful national and multinational agencies have mobilised support programmes to promote global COVID-19 control and research (COVID-19 Clinical Research Coalition, 2020; Rosenthal et al., 2020). Such programmes, we argue, should support rather than constrain low and middle income countries (LMIC)'s abilities to determine public health priorities and to develop contextually appropriate responses to COVID-19 (Kelley et al., 2020). In particular, the voices of those most affected by the pandemic should be meaningfully included in determining what research takes place and how (Nuffield Council on Bioethics, 2020). Additional calls have been made to ensure that both approaches to scientific discovery, and to sharing the benefits and burdens of COVID-19 research, are equitable (Coleman, 2020; Kavanagh et al., 2020).

These calls highlight the ongoing importance of paying attention to the decolonization of global health and global health research. Decolonization, however, is a complex multidimensional process that calls for equally complex and sustained engagement. We argue that any successful programme of decolonization in the context of the current and future pandemics requires a complex three-dimensional approach which recognises and responds to research norms that increasingly prioritise open science and open data. Such norms are transforming knowledge production landscapes, with the potential to exacerbate epistemic injustices. Below we contextualize the problem of decolonization of global health research within the broader discourse of political decolonization that has been going on in Africa, especially in the twentieth century. Given the complex and multi-layered nature of colonialism and neo-colonialism, we unpack the task of decolonization by offering a three-dimensional approach with hegemonic, (a shift of greater power and decision making to local actors); epistemic, (a revisiting of the intellectual and cultural models governing the generation and sharing of knowledge); and commitment elements, (a conscious decision to engage with and make research also accountable to local communities).

Contextualizing decolonization

Calls for decolonization in academia have been made by leading African thinkers

since the latter half of the twentieth century. The Ghanaian philosopher, Wiredu, in several essays has been an advocate for a conceptual decolonization of African philosophy. He sees decolonization as ‘divesting African philosophical thinking of all undue influences emanating from our colonial past’ (Wiredu, 1988). The crucial word in this formulation is ‘undue.’

On a wider scale, an important moment in the drive towards decolonization in academia was the 2015 #RhodesMustFall movement that started at the University of Cape Town and quickly spread to many universities in South Africa and other parts of the world including Harvard, Princeton, Cambridge and Yale (Ntsebeza, 2018). Mainly driven by student activists, the movement called for a ‘decolonization of the curriculum’ and opposed what was seen as Euro-centrism in academic programmes. Similar calls were seen in the field of global health research when in February 2019, students at the Harvard T.H. Chan School of Public Health organized a packed conference that underlined the need to decolonize global health (Saha et al., 2019). Similarly, in March 2019, at the 5th Africa Health Economics and Policy Association (AfHEA) conference, in Accra, Ghana, the need for decolonization of global health received great attention (Offiong, 2019). The Africa Oxford Initiative (AfOx) dedicated its annual conference Focus on Research Africa (FORA) in May 2019 to the question of equitable research collaborations between Africa and other part of the world (AfOx, 2019).

Decolonization is also a focus of recent scholarly publications. Eichbaum et al. highlight structural imbalances in partnerships between HIC and LMIC institutions and offer models of how decolonize existing inequities (Eichbaum et al., 2020). Hickling presents a case for decolonizing mental health in Jamaica (Hickling, 2020). Rodney, drawing from her experience as a Canadian in Ethiopia, reflects on the need to decolonize assumptions in health professions’ education (Rodney, 2016). With the onset of the COVID-19 pandemic, a Lancet editorial calling for the decolonization of COVID-19, concluded that the pandemic is a clear reminder that the colonization of medicine, economics and politics remains alive in Africa, and calls for new systems rooted in recognition, reciprocity and respect (Editorial, 2020).

Recent discourses about global health decolonization may gain valuable insights from discourses about decolonization in the African context like the works of John Mensah Sarbah dating from the latter part of the 19th century (Sarbah, 1968). The independence movements that swept across the African continent in the 1950s and 1960s became concrete and historic examples of the drive to free peoples from the bonds of colonialism. As African countries began

to gain political independence from European colonial powers, colonialism transformed itself into what Kwame Nkrumah of Ghana decried as neo-colonialism. In the introduction to his *Neo-Colonialism, The Last Stage of Imperialism*, Nkrumah stated that:

The result of neo-colonialism is that foreign capital is used for the exploitation rather than for the development of the less developed parts of the world. Investment, under neo-colonialism, increases, rather than decreases, the gap between the rich and the poor countries of the world. The struggle against neo-colonialism is not aimed at excluding the capital of the developed world from operating in less developed countries. It is aimed at preventing the financial power of the developed countries being used in such a way as to impoverish the less developed (Nkrumah, 1965: 2-3).

Nkrumah's fear was that the apparent handing over of political power to indigenous Africans was insufficient to free peoples from the yoke of colonialism. The more subtle form of colonialism, that is neo-colonialism, employed economic capital, and epistemic and cultural imperialism to perpetuate the colonial framework. Fanon put it even more sharply when he questioned: 'Was my freedom not given to me then in order to build a world of the You?' (Fanon, 2008: 181).

Global health decolonization activists can learn from the experience of the 20th century independence struggles. This experience shows that decolonization needs to be addressed in all its complexity if it is to escape the pitfalls of some newly independent African nations. Apart from the risk of neo-colonialism which upholds the apparent handing over of power to indigenous LMIC actors and yet holds onto the reins of power through economic and cultural means, global health decolonization activists would also need to examine why many promising African countries quickly sank into an endless quagmire of poverty, internal conflicts and disease barely a decade after independence. This may require revisiting Appiah's critique of the underlying assumptions of race and identity that were in vogue at the time of independence (Appiah, 1993). Or engaging with Meredith's discomfiting description of the failings of post-independence African leaders (Meredith, 2011). The literary works of Armah (1988), Thiong'o (2018) and Achebe (1988) also provide insights into questioning whether some independence and decolonization activists were more interested in grabbing power from the colonizers than improving the lot of their peoples.

Effective decolonization of global health research requires a robust framework in which LMIC researchers are as empowered as their high income country (HIC) colleagues to generate research questions, knowledge, and solutions to

global health problems. It does not however end there; true decolonization is about achieving the ultimate goals of global health, that is ‘improving health and achieving equity in health for all people worldwide’ (Koplan, 2008: 3). Thus, even though a key protagonist of global health research decolonization is the community of LMIC researchers, the benefits must be for all people, especially the more marginalized and vulnerable. In other words, researchers are not only accountable to powerful stakeholders in global health, but also to the people, *salus populi, lex suprema est (the health and welfare of the people is the supreme law)*.

At a policy level, the normative and practical importance of addressing global health inequities and the needs of the most vulnerable populations has global recognition. Determining ethical, socially appropriate, contextually-sensitive, evidence-based and accountable ways to progress towards these will require strong national ownership and global support, in addition to effective means of addressing power imbalances and promoting meaningful engagement both within and between national and multinational contexts. In practice, promoting the health of populations requires complex decisions to be made about how best to allocate limited resources amongst competing priorities, within complex socio-political contexts involving multiple public, private, national and international stakeholders with varying values, remits, capacities, interests and authority.

Decolonization in the context of global health research is thus a broad concept embracing different themes and stakeholders. The themes include the setting of priorities, funding, epistemic discrimination, educational models, power imbalances, uneven distribution of benefits, unequal opportunities, and rewards, among others. The stakeholders include HIC funding governments and private institutions, HIC researchers and their institutions, LMIC governments, LMIC researchers and their respective institutions, research participants, local communities, and citizens of LMICs. The complex nature of the themes and the multi-layered structure of the stakeholders suggests that attempts at decolonization, if they are to be successful, require a multi-dimensional approach.

A three-dimensional approach to decolonization

To effectively address the complex and multi-layered challenges of decolonising global health research, we propose 3-D model whose dimensions or fields of agency are hegemonic, epistemic and commitmental. This approach is oriented towards the key protagonists at the coalface of such research: researchers and research institutions in LMICs. The dimensions are interwoven and there is no hierarchy; they all have to be pursued if the goal is to achieve effective

decolonization. The challenges that need to be addressed are different in each dimension. In what follows, we shall examine the salient challenges peculiar to each dimension.

Hegemonic dimension

Colonialism and decolonization have to do with a redistribution of power. The hegemonic dimension of global health research decolonization is the effort to ensure that the mechanisms and structures of colonialism and neo-colonialism that assign a disproportionate amount of power to specific multinational and HIC stakeholders is redistributed in such a way that LMIC research institutions and researchers are empowered to generate research questions, knowledge and solutions to global health problems.

As one example, the monitoring and evaluation of progress towards addressing global health priorities relies heavily on data for decision making, priority setting, funding, and policy design. However, the selection of what is measured, how it is measured, and the ways in which measurements inform decision-making and practice can be perceived as inherently political and contentious (Mahajan, 2019; Yamin, 2019). Consequently, rather than being objective and scientifically authoritative, metrics have been perceived as reinforcing power imbalances between global health actors by incorporating measurement methods which interpret norms, carry value judgements and theoretical assumptions; and privilege specific interests, forms of knowledge and outcomes (Fukuda-Parr and McNeill, 2019). For example, after reviewing available literature on mental literacy in sub-Saharan Africa, Atilola came to the conclusion that: ‘Quantitative modes of assessment were the most common, and authors—especially those that adopted this mode of assessment—did not take full cognizance of socio-cultural underpinnings of the concept of mental health literacy in their conclusion and recommendations’ (Atilola, 2015: 1).

A hegemonic decolonization would require giving greater liberty to LMIC researchers to set priorities that are better attuned to local needs. The position of international funders and key stakeholders would be perceived less as drivers of global health research and more as promoters of LMIC researchers’ approaches to developing contextually-relevant solutions to health needs. Additionally, LMIC academics and researchers, who would otherwise shy away from political engagement may need to actively campaign for more research funding from their own governments. African nations which have a large burden of global health challenges are also notoriously reticent in investing in research and development. Whereas South Korea invests 4.8%, Germany 3.1%, and USA 2.8% of GDP in research and development, South Africa invests 0.82%, Kenya 0.8%, Ghana 0.4% and Cote D’Ivoire 0.1%. In 2007 the African Union set a target of 1% but the regional average in 2015 shows that countries are spending just about 0.4% of GDP (Simpkin et al. 2019: 2). When research funding is predominantly driven by foreign funders, LMIC researchers have to orient their research to the priorities of these funders, and be accountable, in the first instance, to such funders, rather

than their own communities.

It is also important to recognize that the research response to COVID-19 takes place against within a context where increasing recognition of the need for collective action to address global health priorities has driven a rapid expansion of global health data sharing, transforming knowledge production. In complex emergency contexts involving multiple national and international actors there have been widespread calls for rapid data-sharing, at times from settings with limited established policies and processes for sharing data (Modjarrad et al., 2016; Pisani et al., 2018). Within the specific context of COVID-19 powerful stakeholders have highlighted the importance of sharing interim and final research data relating to the outbreak, together with protocols and standards used to collect the data, as rapidly and widely as possible (Wellcome, 2020) .

Multiple concerns have been raised about procedural fairness and a lack of engagement with LMIC stakeholders during developments in global health research landscapes, and about consequent implications for practice (Anane-Sarpong et al., 2018; Bezuidenhout and Chakauya, 2018; Bull, 2016; Serwadda et al., 2018). Normative concerns arise about methods of data sharing which, if focused too narrowly on maximising data availability and utility, may marginalise the contributions of LMIC researchers (Editorial, 2018), and perpetuate epistemic injustices by failing to give proper respect to all individuals as knowers and sources of information (Santos, 2014). Empirical concerns arise about failing to promote the participation and recognition of health researchers who shared data, leading to a risk that secondary analyses will be less relevant to, and less likely to inform policy development within, contexts from which data are collected (Merson et al., 2018).

An area of concern arising from the above is the enhancement of the capacity of local researchers in data collection and analysis. However, initiatives of ‘capacity building’ have sometimes been interpreted as enabling LMIC research institutions and researchers to be able to carry out the type of task that are currently executed mainly by HIC institutions and researchers. This response which in practice often involves training programmes for LMIC researchers may, as Bamford points out, contribute to reinforcing the existing hegemony, using local actors (Bamford, 2019). Beyond a simple transfer of power towards local agents, hegemonic decolonization, there is a need for an epistemic decolonization.

Epistemic dimension

A look at some of the failures of the political independence movements in Africa reveals that many newly independent states continued to operate within the epistemic framework established by colonizers. Political systems, government structures, educational curricula, and lingua franca, mostly continued along the same lines that had been introduced by the colonizers. As Appiah points out, for many rural Africans, independence brought little change to their colonized lives (Appiah, 1993: 168). Armah is even more sarcastic about this in his novel ‘The beautiful ones are not yet born’ when he describes the new post-independence

rulers of Ghana as hurrying to occupy the houses and positions formerly occupied by the colonizers and striving ridiculously to imitate the tastes and habits of the former masters (Armah, 1988).

Challenging the hegemonic structure of global health research is not enough to achieve decolonization. The task of epistemic decolonization is much more laborious. Pragmatic pluralist accounts of knowledge production in the philosophy of science contend that both scientific knowledge, and what counts as data, are best understood as relational and *mutable* (Leonelli, 2015; Longino, 2002). As such they are contextually embedded and influenced by social, political, cultural, and economic factors, including communities of stakeholders with differing, and at times conflicting, interests (Shiffman, 2014). Differing forms of power have differing domains of application, influence, and visibility in relation to shaping actors' choices and actions at international, national, institutional, and individual levels. Dahl's account of compulsory and direct expressions of power are evident in funders' control over the financial resources required to conduct global health research (Dahl, 1957). Structural expressions of power influence norms and practices which affect how research proposals are developed, and which agents and perspectives are privileged over others (Haugaard, 2012). Accounts of productive or discursive power focus on how meanings are produced, fixed, lived, experienced and transformed, including how discourses frame the ways in which stakeholders think about global health research, including what is perceived to be normal, acceptable and legitimate (Lukes, 2005).

As the leaders of the 'Rhodes must fall' movement in South Africa pointed out, the curricula of many African universities are more Euro-centric than Afro-centric (Ntsebeza, 2018). The challenge, however, is not just to change the curricular content, but also to promote what Wiredu describes as conceptual decolonization (Wiredu, 1988). As Rebecca Bamford points out for global bioethics, at play are direct and indirect forms of moral neocolonialism:

direct colonialism converts people's values to those of a dominant ethical system covertly, through aid, partnership, e.g. via a government, NGO, or research organization. Indirect moral neocolonialism produces the conversion of people's values to those of the dominant system through systemic and epistemic injustice, and global white ignorance. Both forms of neocolonialism may be present at once and may reinforce one another's effects (Bamford, 2019: 50).

What is needed ultimately is a revisitation of the frameworks and conceptions of health, research and ethics to ensure first that they are not unjust towards indigenous knowledge systems, and that they are open enough to include both indigenous and foreign knowledge systems. To achieve this, African researchers who have mostly been trained in the Western scientific tradition will need to become more aware of their own pre-judgments in relation to traditional knowledge systems and be willing to engage in a type of dialogue that can lead to a 'fusion of horizons' (Gadamer, 2004). It is the type of exercise, described

by Kwame Gyekye as ‘critical sankofaism’, which requires critically unearthing African pre-colonial epistemic and value systems that are relevant to current challenges (Gyekye, 2015).

The training of many African scientists relies on the Western positivistic model which, as Taylor carefully shows, is linked to a particular historical evolution of ideas in the Euro-American context (Taylor, 2007). African cultures for their part mostly still subscribe to a cosmivision that accommodates metaphysical ideas similar to what Taylor calls an enchanted universe. This means that African scientists often approach local knowledge systems from an etic viewpoint which imposes a standard that all knowledge has to conform to. An example in the COVID-19 era is the case of the Food and Drugs Authority in Ghana closing down laboratories and arresting producers of local medicines being offered as cures for the coronavirus (Anas, 2020). Whereas such actions are seen as laudable efforts to defend innocent persons from deceit and from potentially harmful drugs, what the Authority fails to capture is that the mechanisms and bureaucratic procedures for the approval of new drugs render it almost impossible for local herbalists without formal Western style education to be able to obtain the required approvals. Hence, the Authorities, perhaps with the best of intentions, become agents who perpetuate the testimonial injustice introduced by the former colonizers. In this regard, Cloatre observes,

even as regulatory systems set out to recognize some forms of traditional medicine, they often operate on assumptions that disqualify knowledge, products, and actors that do not resemble their biomedical counterparts. Consequently, traditional healing systems either operate outside the law, or adapt to it by transforming themselves to align to ‘legitimate’ systems of law and biomedicine. While such regulatory movements have long historical roots, they have been intensified by the advance of industrialization in biomedicine and the expansion of global markets in medicine (Cloatre, 2019: 424).

African researchers, whilst respecting the etic exigencies of critically scrutinizing locally generated knowledge, will need to include an emic approach to their evaluations. This will require fluency in local knowledge systems in order to be able to appreciate and understand issues from the subjective viewpoints of their communities. For example, many African frameworks conceive of health as the natural or normal state of being. Ill-health is therefore an anomaly, to which a cause must be attributed. Drawing from the Yoruba word ‘alaafia,’ Gbadegesin explains that health is holistic concept that embraces a person’s physical, social, psychological and spiritual well-being. When a person lacks ‘alaafia,’ she is considered to be in a state of dis-ease. The task of healthcare is to reinstate the condition of ‘alaafia’ (Gbadegesin, 1991).

Within this framework, the aetiology of conditions of ill-health is not limited to a search for the biochemical causes, but instead requires taking into account relational and social dimensions that can lead to illness. A very narrow biomedical framework may fail to meet the expectations of patients and care givers. It is

therefore hardly surprising that people recur to multiple forms of health care in Africa, such as going to hospitals to cure symptoms and looking for spiritual diviners and healers to address the other causes of the condition. The emic effort of decolonization requires that African health care providers understand the framework of patients and care givers and adjust their own pre-judgments to be able to come up with a framework that is broad enough to take into account these cultural notions and perceptions without losing scientific rigour.

The task of epistemic decolonization is ultimately a long-term project of challenging the academic cultural hegemony through which former colonial powers influence education, set standards and exercise intellectual, cultural, and social dominion through an imposed and often undeclared cosmivision or metaphysical framework.

Commitmental Dimension

Research is a specialist activity that is carried out by highly qualified persons who belong to institutions. Researchers in African institutions belong to a privileged class within their own communities. This places them in a position of power with respect to a larger part of the population of their own countries. In global health research, where the goal is to improve human health, engagement with relevant publics, communities and stakeholders is increasingly recognized as an important element of procedurally fair research practices (Council for International Organizations of Medical Sciences, 2016). In the context of pandemics engagement plays a critical role in contributing to the protection of, respect for, and empowerment of participant communities (World Health Organization, 2020), as well as in ensuring that research is relevant to local health priorities (Nuffield Council on Bioethics, 2020). Care is needed to develop processes which can address power imbalances and enable meaningful engagement with diverse stakeholders, including women and marginalized populations (Neupane et al., 2018).

In the context of former colonies where indigenous culture has historically been marginalized in academia and knowledge production, researchers will need to make a conscious effort to engage with local communities. Borrowing from Gyekye, we call this effort commitmental because it requires a positive agency to build stable co-responsible relations with stakeholders who often do not feel empowered enough to engage or to be engaged (Gyekye, 1997). This dimension of decolonization is important because colonialism and post-independence neo-colonialism generate attitudes of apathy and distrust towards public institutions. It also produces a climate whereby persons in position of power do not feel accountable towards their communities, but rather towards their ‘masters.’

A commitmental decolonization agenda thus requires a substantive and long-term approach to engage with and establish relationships of trust between researchers, research institutions and local communities. As O’Neill points out, building trust is not an abstract exercise (O’Neill, 2018). It requires trustworthy persons and trustworthy institutions. Three conditions are necessary for the

establishment of this type of trust. First, researchers and research institutions must be competent. They must be capable of offering real answers and solutions to the local problems. In the case of global health research, African researchers will need to offer solutions and answers to some of the endemic health challenges on the continent. If solutions to the many local health challenges such as sickle cell anemia or malaria have to be imported from outside the continent, it impacts the perception of confidence of local researchers. Second, researchers have to be reliable, that is present when needed and to deliver on their promises. Communities can have the impression that researchers are only interested in them when they need to gather data, after which they disappear only to reappear again when more data are needed. Institutional and permanent restructuring might be required here to ensure that community engagement becomes part of a permanent ongoing conversation between researchers and communities. Third, researchers will need to make themselves accountable to the communities with which they are engaging. This requires becoming vulnerable to being challenged and questioned by community members regarding research choices and methods. It also requires envisaging structures and procedures that will ensure equitable distribution of benefits of research with communities.

Addressing Possible Objections

The model for a project of decolonization we have so far advanced may seem to present an idealistic version of indigenous frameworks that fails to address some of the common challenges that researchers encounter when engaging with traditional African communities. For example, moralizing views tend to interpret illness as something caused either by another person (witchcraft) or the sick person's moral failings.¹

This objection, in our opinion, buttresses the model we are proposing. Cultural and cosmological viewpoints of peoples are constantly evolving realities that adapt to new discoveries either by accommodating them in existing models or by abandoning older models for newer ones. An example of the latter is the shift from a geocentric to a heliocentric astronomy in post-sixteenth century Europe. The former, an adaptation to new discoveries, especially within religious contexts, is how mainstream European Christian eschatological beliefs, which include the doctrine of the resurrection of the dead, have evolved theologically from an initial rejection to a more accommodating view of cremation of the dead. Such adaptation requires a revisitation of the underlying concepts and values that inform the normative views that are prescribed at a given time. Often, as in the case of cremation, one may find that there is room, at a deeper metaphysical and axiological level, to broaden existing praxis or norms to accommodate the novel.

From this viewpoint, Kwame Gyekye's analysis of the African concept of causation offers a framework of interpretation that can be applied to the objection of 'witchcraft' or 'moralizing' of illness. For the Akan and Yoruba, like many African peoples, health is a composite outcome of physical, non-physical, and

¹ Thanks to an observation from an anonymous reviewer.

social relations (Gbadegesin, 1991). Illness is seen as an unnatural condition of being human, hence, it must have a cause. The Akans say, ‘when a palm tree tilts it is because of what the earth has told it’; i.e. palm trees do not tilt without a cause (Gyekye, 1995: 77). Gyekye makes a distinction between two types of why-questions or causal questions often asked by Akans. These why-questions he labels as why-1 and why-2. Why-1 questions are questions asked about regular events which normally require empirical explanations. For example, poor rainfall as the cause of poor harvest. Why-2 questions are questions that are asked about extraordinary events which have supernatural causes. According to Gyekye, Akans are more interested in why-2 questions. The answers to why-2 questions are generally found in the supernatural realm. Practices that are often deemed as ‘witchcraft’ in healthcare try to offer answers to why-2. They do not, however, exclude the need to look for empirical solutions to health conditions. Gbadegesin clarifies even further: ‘contrary to common misconceptions, and in spite of the appeal to supernature in causal explanation, neither the Yoruba nor the Hausa (nor other African cultures) make an immediate appeal to the supernatural to explain illness’ (Gbadegesin, 1991: 128). Physical ailments are generally attributed to physical factors and are cured traditionally with herbal medicines, specific foods, and potions. The challenge arises when the physical and communal dimensions are neither able offer a full causal justification nor definitive cure for the condition.

This perspective underscores the importance of an epistemic and committmental decolonization that is cognisant of the need that people may have for why-2 answers. Epistemic colonization with its emphasis on the empirical and its accompanying denigratory attitude towards indigenous beliefs runs the risk of classifying as ‘witchcraft’, what is plausibly a legitimate desire to better understand the causes of an illness. The point we are making here is that a more profound engagement with African cosmological systems might reveal that they do have a framework that is compatible with modern scientific practice without necessarily discarding the possibility of metaphysical realities.

Conclusion

The COVID-19 pandemic is shedding light on the many cultural, political, and social factors that influence health and health care delivery. In the context of global health research, the question of decolonization is gaining greater currency. Amidst the call for decolonization, driven by the movements and the current pandemic, and drawing from the independence movements of the process of African decolonization, we have highlighted the multiple dimensions and dimensions of engagement necessary for a sustainable and enduring process of decolonization. If the benefits of global health research are to be shared

equitably among the various stakeholders who currently exercise different dimensions of power, a careful multi-dimensional approach will be required to create a truly decolonized model that empowers all.

Caesar Alimsinya Atuire
Senior Lecturer
Department of Philosophy and Classics
University of Ghana
email: atuire.ca@gmail.com

Susan Bull
Associate Professor in Bioethics
Wellcome Centre for Ethics and the Humanities and The Ethox Centre, Nuffield
Department of Population Health, University of Oxford
email: susan.bull@ethox.ox.ac.uk



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