OPINION EDITORIAL

Abolition, global health, and the urgent need to decolonize and recenter communities

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Global health institutions in the North, situated on stolen Indigenous lands and waters, have begun admitting the realities of neocolonialism and racism in their governance, practice, and research. However, approaches towards transformative justice for the communities, which the global health paradigm has caused through its extractive, exploitative, and racially violent nature, are virtually absent. Now that colonialism has been named in the global health sector, there is an urgent need to dismantle, reimagine, and rebuild approaches to global health through the lens of abolition.

Abolition and global health praxis

Abolition provides a vision and an analysis of structural oppression and structural power; it is a framework for addressing harm and dismantling, reimagining and rebuilding. It lends the possibility of new structures, collective action, wellness, healing, health, and accountability. [1] From enslavement, police, and prison abolitionist movements, we have learned that naming colonialism, racism, and oppression in our institutions and sectors is not enough, especially as they continue to cause violence and harm [2]. We ask the sector: what is the purpose of naming colonialism in global health governance, practice and research without a movement to urgently redistribute power and seek justice for those harmed, led by the individuals and communities most affected? The power imbalances in the global health sector are stark and indisputable. [3].

Predominantly white countries, institutions and researchers hold decision-making power at every level. They ultimately set the agenda and the budget for the issues (said issues often rooted in historical and current exploitation and violence to communities perpetrated by the global North) to prioritize in addition to how and whom will address them. They decide which communities will be the "target populations" for interventions. Predominantly white-led groups and organizations extract information, experiences, and stories from folks in the Global South for publication, presentation and distribution in the Global North, ultimately, for profits, funding, notoriety and more power [4]. This extractive cycle is neocolonial. Neocolonialism, much like colonialism itself, is violent, racist, and oppressive [4].

Abolition does not stop at naming the cycle of neo-colonial violence, oppression and racism in global health governance, practice, and research. Abolition provides a framework to critically decolonize and decentralize systems. It lends the analysis of the root causes of global health inequities between the North and the South, with history in mind. It prompted Abimbola et al. to ask the question: "Can global health be equitable when the world itself is not?" [5], which is a prompt to hold global health decision-makers, practitioners, and researchers in the global North accountable for pervasive power asymmetries and injustices that are exacerbated by the nature of the sector.

How COVID-19 exposed the violence of colonialism and capitalism

We need not look far to find instances where global capitalist and imperialist structures have caused continued harm to communities in the so-called Global South. In the early days of the COVID-19 pandemic, public health messaging and news outlets rang out feel-good sentiments that "we are all in this together" and encouraged us to socially distance, mask, and take care of one another. Two years later, it is incredibly clear that "we are all in this together" could not be further from the truth. We were never all in this together.

When vaccines were made available, countries in the Global North began hoarding them. These countries drew a line in the sand, siding with the profit-driven interests of multinational pharmaceutical firms by refusing to sign the TRIPS waiver [6], which would ensure expedited and equitable access to the lifesaving COVID-19 vaccine for countries in the Global South. Those violent lines in the sand are also known as borders. Harsha Walia in *Border and Rule*, positions borders as a source of violence for oppressed and repressed communities across the world - borders are key to maintaining colonial rule and solidifying capitalist, nationalist interests and preserving imperial power [7].

Those lines in the sand scar not only our land but our social imagination. The prison industrial complex continues to demarcate society across racialized lines. Angela Davis in *Are Prisons Obsolete?* tells us that "the ideological work that the prison performs—it relieves us of the responsibility of seriously engaging with the problems of our society, especially those produced by racism and, increasingly, global capitalism." [8]

Though incarcerated individuals remain a high risk population for contracting COVID-19 (due to inhumane carceral living conditions), as well as experiencing severe symptoms, public health messaging in the North widely omits that reality. [9]

For example, the Government of Canada does not list incarcerated individuals as "people who are at risk of more severe disease or outcomes from COVID-19," though scientific evidence tells us otherwise. [9] [10].

Borders, much like prisons, are a tool of colonialism and capitalism to justify neglect and harm - they're utilized as a mechanism for dehumanization. The true cause of harm and violence is not what happens within prisons and within borders, it is in the very nature of their existence.

Global health institutions exist, operate within, and uphold this paradigm of borders, prisons, and global capitalist violence. Equity-based responses to these harms are not transformative nor systemic. Downstream reactions will never replace the value of true, radical transformative change. It is time for justice.

Calls to Action

Following the direction of communities, namely BIPOC (Black, Indigneous and People of Colour) communities, our call is to divest from global health entities and structures that uphold colonial practices and gate-keep transformative justice and reparations for communities oppressed by global health funding, practice, research and governance.
We call on those who hold power in the field of global/public health to:

1) Acknowledge the power imbalances that exist in the global health sector (in research, profits, funding, decision-making, authorship, governance, "informed consent" of individuals and communities etc.) between predominantly white and Northern regions and Black and Brown Southern regions;

2) Divest from global health research, programming and projects that enact harm – such as unsustainable, extractive and exploitative practices that subject communities to racism and racial trauma;

3) Divest from global health work and organizations that perpetuate ideologies and practices of racism, racial trauma, colonialism and imperialist interventionism;

4) Divest funds from predominantly white organizations and invest in community-led organizations and groups in regions where health inequities persist;

5) Re-focus global health investments into communities most affected by health inequities, not as charity, but as reparations and transformative justice for historical and current colonialism and exploitation;

6) Invest in community-led and community-based groups and organizations who address the root causes of global health inequities through an intersectional lens;

7) Align global health praxis with the abolitionist movement.

The power of abolition is not just in recognizing violence but in dismantling the very systems that create it, and investing in communities to ultimately construct a new vision for the future, where health is a human right and a form of justice. We leave with the apt words of Harsha Walia: "Empires crumble, capitalism is not inevitable, gender is not biology, whiteness is not immutable, prisons are not inescapable, and borders are not natural law."

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