Shifting power in global health will require leadership by the Global South and allyship by the Global North

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Global health continues to be a field where Global North actors see themselves as leaders.[1,2] Although the decolonising global health movement has exposed the deep inequities inherent within the architecture of global health,[1] this movement, prone to elite capture, faces several institutional barriers that prevent meaningful shifts in power.[3]

First, the wider political context in many countries has worsened inequities in global health. In several countries a steady erosion of democracy and the emergence of nationalistic and autocratic leaders have resulted in government policies that are antithetical to equity in global health. From hoarding of life-saving health products[4] to anti-immigrant and anti-refugee policies,[5] regressive policies are making reciprocal and equitable global health partnerships challenging. Global South experts are often missing from major fora, job searches, or conferences because of exclusionary visa policies by many Global North countries.[5] Nationalism and populism were evident in the COVID-19 vaccine hoarding by some high-income countries (HICs).[6] Despite having large stockpiles of mpox vaccines, HICs have shared little to help Africa deal with the ongoing mpox outbreaks.[7] Lack of support for TRIPS intellectual property waivers, as well as the pushback against equity and access and benefit sharing clauses within the draft Pandemic Treaty, suggest that the priorities of HICs and the commercial interests of pharmaceutical companies remain influential.[6,8] A similar nexus between political leaders and fossil fuel companies prevents adequate action on the climate crisis, which disproportionately affects Global South nations.[9] Wealthy, polluting nations have shown little interest in contributing to the Fund for Responding to Loss and Damage that was intended to advance the cause of climate justice.[10]

Second, Global North funders, donors, and philanthropic organisations have enormous influence on all aspects of global health.[11–13] They often decide who leads organisations,[14] who receives funding,[11] and what interventions are prioritised.[13] And most Global North universities and international non-governmental organisations are unwilling to discuss the disproportionate influence of wealthy donors because they fear jeopardising their own funding.[13]

Third, Global North universities are often reliant on overheads that come with global health funding. It is not in the best interests of Global North institutions for funding to go directly to Global South partners or communities.[15] Even suggestions to offer institutions in low-income and middle-income countries (LMICs) an equitable share of overheads face challenges, because of the fear that Global North funding levels will decline because of that.[15,16] Additionally, Global North universities see global health degrees as a source of revenue, and many charge high tuition fees for international trainees.[17]

Fourth, Global North universities often hire global health academics with grant or contract-based funding (soft money).[18] Tenure, even if it exists, can mean little when faculty members get little security or support from their institutions.[18] There is great pressure on many global health faculty members to apply for grants and contracts to cover a major proportion of their salaries. This institutional pressure and precarity force academics to prioritise their own career advancement, even when many Global North scholars genuinely want to walk the path of allyship with colleagues in the Global South.[19] The results can be seen in how grants often go to Global North institutions, even when the research is entirely done in LMICs, or even when Global South researchers are best placed to lead the research agenda.[11,15] This power imbalance is also evident with authorship inequities in global health research; first and senior authors are often from HICs, as they need publications to get promoted, get grants, and get known.[20] Similarly, global health awards and prizes often go to HIC individuals and organisations.[21] Given this context in which promotions and tenure expectations at Global North universities are mostly based on individual success in criteria such as number of first or senior authored publications, number of grants held as principal investigator, prizes, citations, and keynote lectures,[22] allyship and partnership-building work is rarely recognised or rewarded by promotions committees.[19] Without institutions changing their

promotions policies and academic incentive structures, it is unlikely that individuals alone can advance equity.

Lastly, while diversity, equity, and inclusion (DEI) initiatives brought some hope for increasing diversity and inclusion within global health organisations, 4 years after the murder of George Floyd in the USA brought global attention to racism, there is growing backlash against DEI, especially in the USA, where more than 80 anti-DEI bills have been introduced since 2023.[23,24] Equity efforts might be losing steam in global health academia, and experts working on DEI are at risk of stress and burnout.[24,25]

All these systemic barriers are interconnected and are partly tied to the neocolonial, capitalistic, hetero-patriarchal model that reinforces coloniality within Global North institutions and governments.[26] It is not in the nature of power to shift power. Although many individuals work hard to decolonise their own work and actively adopt anti-racist and anti-colonial practices, decolonising their institutions or governments is very difficult.[26] Despite these challenges, it is possible for Global North institutions to decentre themselves, shift power, and demonstrate allyship.[19,27] We propose some examples of what is possible for Global North allyship (table).[28–36]

At the same time, we remember the words of the American abolitionist Frederick Douglass (1818–95) who said, "power concedes nothing without a demand. It never did and it never will."[37] We believe the biggest progress will come from leadership by Global South nations, institutions, and people, as they seek to exercise their agency and challenge the saviourism, charity model of global health.[4,6,38] LMIC actors need to claim positions they have historically been denied in the places and organisations where decisions are made in global health, and lead an agenda centred on self-determination and self-reliance.[4] We also propose some examples of such Global South leadership (table). Genuine South–South solidarity and strong southern networks will make it substantially easier for Global South institutions to demand a shift in power.[2]

	Examples of how Global North institutions can demonstrate allyship	Examples of how Global South institutions can demonstrate leadership
Governments	Policies that discourage hoarding of life-saving health products and encourage rapid sharing of data and technologies during crises[8] Support for a global Pandemic Accord with strong equity and accountability clauses[8] Visa policies that allow greater Global South representation in fora and meetings[5] Contribute to the loss and damage fund to support Global South nations in climate change mitigation and adaptation[10] Debt relief for low-income nations, especially in Africa[28] Policies that promote, not oppose, DEI and anti-racism initiatives[23]	Invest more in health, and be less reliant on donors[2] Invest in national and regional health institutions, health workforce, civil society, and research institutions[34] Invest in building national and regional manufacturing capacity to make drugs, tests, vaccines, and technologies[34] Improve accountability and transparency
Funders and donors	Directly fund Global South institutions and affected community organisations without strings attached,[11,12] and offer a fair share of overheads to such organisations[16] Invest in building strong institutions and infrastructure in the Global South by providing resources outside of narrow grant funding	Increase investments, and reduce reliance on Global North funders[34] Ensure a fair share of overheads to build research infrastructure[16] Fund local partners as leaders of the process of knowledge production and use[2] Ensure that reciprocity and bidirectional partnership is included in grant agreements and memoranda of understanding[2]
Academic institutions	Reduce tuition fees for trainees from LMICs and offer scholarships[1,17] Build equitable and bidirectional partnerships; ensure reciprocity and host trainees and experts from LMICs[2] Change tenure and promotions criteria to acknowledge allyship and trust-building efforts[2]	Institute clear policies to discourage parachute research and extractive partnerships[2,16] Provide more institutional support (eg, protected time) to encourage academics to take on leadership work globally Adequately support and reward work on Indigenous and Global South knowledge systems[2]
International organisations	Commit to intentional, long-term capacity strengthening of partner institutions in the Global South with an aim of gradually shifting resources and leadership to them Undertake phased self-decentralisation by moving and spreading their current Global North base to different locations across the Global South, with subsequent transfer of ownership[2,27] Go beyond performative DEI and ensure genuine inclusion and diversity[23]	Build strong and accountable organisations in the Global South[2] Take the lead in relocation of organisations to the Global South Acknowledge that even in Global South nations, it is the in-country elites that wield power, and work towards genuine partnerships with people with lived experience[35]
Global health journals	Intentionally diversify editorial boards at all levels (from editor-in-chief to editorial board membership)[29] Ensure article processing charges are not a barrier for LMICs[29] Commission articles from Global South and community experts[29,30] Adopt policies that promote equitable authorship and research practices[31,32]	Build strong Global South journals[36] Global South experts to take on leadership roles in international journals, and advocate for equitable policies on authorship, article processing charges, and diverse editorial boards[29,36]
Conference organisers	Host meetings in visa-friendly countries[5] Alternate meetings between Global North and South locations[33]	Take the lead in organising meetings in Global South nations[5] Remove hurdles for easy travel within Global South countries

Examples of Global North allyship and Global South leadership, by institutions. DEI=diversity, equity, and inclusion. LMICs=low-income and middle-income countries.

Table: **Examples of Global North allyship and Global South leadership**

We acknowledge the limitations of our Global North versus Global South binary framing,[39] and that there are entrenched, intersectional power hierarchies, elite capture, and corruption within Global South nations, and that in-country elites can be co-opted to maintain the status quo.[35] Thus, even within Global South nations, the elite will have to shift power, and be allies to equity-denied communities and people with lived experience.

To reimagine global health and shift power to people and institutions on the margins and the periphery,[40] everyone in global health must advocate for and activate two forces: leadership by the Global South and allyship by the Global North. It is the synergy of these dual forces that is required to disrupt the status quo and tip the scales in transforming global health into a model rooted in justice, equity, global solidarity, and collective liberation. In an era of polycrisis and widening inequities, global solidarity and global citizenship are not mere buzzwords—they are crucial for our collective survival.

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