COVID-19: Reflecting on the role of the WHO in knowledge exchange between the Global North and South

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The world learnt of cases of an unknown pneumonia in Wuhan, Hubei province, China in the last week of December 2019. On the 30th of January, the World Health Organization (WHO) declared the COVID-19 epidemic as a public health emergency of international concern (PHEIC) (World Health Organization (WHO), 2020d). This prompt response by the WHO stands in contrast with the responses the organization exhibited in other recent outbreaks, particularly of Ebola in West Africa (Wenham, 2017). COVID-19 as a truly global pandemic presents a unique opportunity to reflect – through an ‘anti-colonial’ lens – on the role that WHO plays in low- and middle-income countries (LMICs) versus high-income countries (HICs). This divide, also referred to as the global south and the global north, coincides in many ways with the separation between former colonies and colonial powers. This commentary will use COVID-19 as a case study to argue that the WHO can contribute to the redistribution of power from the global north to south through the horizontal exchange of knowledge and the incorporation of best practice examples from the global south.

Understanding the response of the WHO and the way it manages its relationship with its member states during the pandemic provides an opportunity to further advance the anti-colonial discourse. So far, the organization has demonstrated a leadership role in research and knowledge management for effective pandemic response. For instance, the WHO is leading the Solidarity Trial for treatments and vaccines, a multi-country initiative that aims to make available effective prevention and treatment options for COVID-19 (WHO, 2020c). Even in such cases, however, it is essential to question the foundations upon which knowledge is generated. Historically, knowledge has been presented in the form of technical assistance being offered to ‘developing countries’ by experts from HICs with minimal involvement of local experts from the global south (Fee

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et al., 2016). The directionality of the knowledge transaction has been north–south and not the other way around. This is evident, for example, in the composition of the WHO’s expert committees and the location of its collaborating centres.

Unlike other infectious disease outbreaks, COVID-19 has spread in both HICs and LMICs, exposing the weakness of public health systems in countries of the global north. Resource rich and advanced health systems, like Italy’s, were rapidly overwhelmed (Rosembaum, 2020). Others with less resources, but with strengthened local expertise in previous handling of outbreaks like Vietnam, managed to control the outbreak without jeopardizing their health system’s capacity (Dabla-Norris et al., 2020). Hence, this pandemic provides a unique opportunity for best practices from the global south to be incorporated into the global response strategy, balancing the influence of institutions in the global north on global health knowledge (Ebikeme, 2020). It is worth making the caveat that colonialism is a system of oppression that is not exclusive of institutions in the global north and can also be introjected by the oppressed. However, it is those who are in positions of power, here referred to as the global north, that need to ‘lean out’ and welcome knowledge and practices from the global south. The WHO as a global organization is in a unique position to encourage this.

In March 2020, President Carlos Alvarado Quesada of Costa Rica proposed the creation of a joint research pool for COVID-19 related research, to which 30 member states have already signed up (WHO, 2020b). This research pool aims to provide timely access to patents, trial results and gene sequencing related to COVID-19. This initiative marks a new path for knowledge sharing and international solidarity during a PHEIC. However, only one of the 30 countries supporting this initiative is considered a HIC or part of the global north. Unintentionally, this has become a south–south partnership rather than a global one, demonstrating the type of segmentation that can happen in the circulation of knowledge in global health. It also demonstrates that countries from the global south can take a prominent leadership role in setting the global health knowledge agenda, reversing the stereotypes of being only beneficiaries of knowledge produced elsewhere. Countries in the global south are able to take such bold leadership initiatives during this pandemic in part, due to the nationalistic, rather than global, approach to the pandemic response adopted by some countries in the global north, who have been traditional leaders in global health agenda setting and decision making (Vogel, 2020). This lack of clear leadership by the global north has enabled countries like Costa Rica to step into the gap and drive the agenda-setting process.

It is worth noting that the WHO holds a central symbolic space in global health, as the coordinating authority in international health – one that could help counteract the patronizing rhetoric used by the media and some experts in the global north since the beginning of the pandemic to signal weakness in the global south (Filipi and Wittig, 2020; Okereke and Nielsen, 2020; Yousfi, 2020). These comments are frequently framed as concerns about the wellbeing of LMICs that offer a pervasive narrative around the helplessness and fragility of the global south. Such concerns were being voiced even while the epicentres of the pandemic were in the global north.

HICs such as the United States and European countries, despite being hardest hit, are better equipped with human and economic resources to respond to the crisis, while health systems in some developing countries are struggling to provide an effective public health
response to the pandemic. However, there are also outstanding examples of countries in the global south who have been able to overcome inherent challenges to produce exemplary responses. Uganda, Rwanda, Senegal and Nigeria have all been involved in innovative activities to respond to the epidemic. Such activities include development of simple triaging guidelines to promote diagnosis of COVID-19 cases, improvement of hand hygiene at public transport stations through the provision of handwashing stations, development of cost-effective rapid diagnostic test kits, and the endorsement on social media by influential individuals to promote prevention strategies (Dalglish, 2020). Besides, experience in managing previous infectious disease outbreaks have contributed to the effective response to the crisis by countries in the global south (Munshi, 2020). These experiences demonstrate the need for a different narrative around the pandemic response.

Furthermore, knowledge produced by the WHO to tackle the pandemic have been approached differently by countries from the global north and south. Guidelines developed by the WHO to guide decision-making have been systematically ignored by HICs like the United States and the United Kingdom (Borger, 2020; Wenham, 2020). The actions by these leaders/governments seem to reflect a view that the WHO is meant to serve as a tool to improve the global south, projecting a colonial mind-set (Ebikeme, 2020). The reverse seems to be the case with countries from the global south, where a majority have adopted and incorporated instructions from the WHO as bases for their national response strategy (WHO, 2020a). Although exploring this matter in depth goes beyond this commentary, an important question comes to mind. Do developing countries rely on guidelines from the WHO due to a lack of local expertise to develop country-specific responses with relevant scientific quality? This proposition is highly contestable. LMICs have scientific teams in universities and the private sector who are developing innovative ideas to address the pandemic around COVID-19. For example, Argentine public and private joint research teams have developed a polymerase chain reaction (PCR) test at a cost of eight US dollars, while a research team from the University of Sao Paulo collaborated with Oxford University researchers to sequence the SARS-CoV-2 genome in early February (Llorente, 2020; Fioravanti, 2020). Hence, lack of expertise might not be a sufficient explanation for the uptake of guidelines from the WHO by these countries. Alternative reasons need to be investigated to understand the dichotomy in the uptake of the WHO guidelines as a tool for decision making between the global north and south.

All in all, the WHO has demonstrated strong leadership towards tackling the COVID-19 pandemic, within the ambit of its mandate and structural funding limitations. This pandemic presents a crucial opportunity to refocus prevailing narratives towards a more balanced and nuanced perspective on the impact of COVID-19 in countries of the global south, as well as to incorporate knowledge and best practices from the global south into the pool of knowledge guiding the global response to the pandemic. As discussed with the Costa Rican research pool proposal, the WHO has shown signs of willingness to help counterbalance the colonial dynamics between the global south and global north. Yet, more focused attention needs to be paid by the WHO to champion the democratization of knowledge exchange in global health.
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