

THE COLONIAL LEGACY OF POWER, PROFIT, AND PREJUDICE IN GLOBAL HEALTH GOVERNANCE

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Abstract: This article examines how colonial legacies continue to structure global health financing and governance, perpetuating systemic inequities between the Global North and South, particularly African countries. Historical analysis reveals that colonial health systems were strategically designed to protect European interests while exploiting indigenous populations and establishing racially segregated frameworks whose structural biases persist in contemporary institutions. International financial architecture, particularly through bodies such as the International Monetary Fund (IMF) and World Bank, reinforces these asymmetries through governance mechanisms that privilege wealthy nations in decision-making and resource allocation. The COVID-19 pandemic exposed these entrenched disparities, as vaccine nationalism and disparate fiscal capacities widened the existing health gaps. Emerging digital health technologies now risk establishing new extractive relationships, as health data harvested from vulnerable populations flows to high-income countries without adequate benefit-sharing frameworks, a pattern identified as data colonialism. Addressing these interconnected challenges requires decolonising global health governance through fundamental reforms that redistribute power, ensure data sovereignty, and centre historically marginalised voices in shaping health priorities and financing mechanisms.

Keywords: Africa, colonialism, COVID-19, global health equity, international finance, reinforcing disparities, systemic inequities

Introduction

The global health financing architecture operates within an intricate web of power relations that reflects persistent colonial legacies. Historically, these structures have perpetuated a hierarchical framework wherein formerly

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colonised regions are relegated to passive recipients of aid rather than active stakeholders in decision-making processes (Pearson 2018; Schrecker 2009). This donor-recipient dynamic bears a striking resemblance to colonial relationships, with profound implications for health equity worldwide. The lasting impact of these structures continues to shape the prioritisation of global health initiatives, often reinforcing disparities rather than addressing them. This systematic misalignment manifests in resource allocation and priority-setting processes. Health challenges that receive funding and attention frequently align with the worldviews and interests of powerful states, private foundations, and multinational financial institutions in the Global North, rather than reflecting the actual needs of communities bearing the highest disease burdens (Cobbett 2020). Consequently, the imbalanced distribution of health resources perpetuates structural inequities, particularly in African nations and other regions that remain marginalised in governance frameworks despite shouldering disproportionate health challenges.

The HIV/AIDS epidemic provides a compelling example of these systemic inequities. For decades, while antiretroviral treatments were available in wealthier nations, many African communities struggled to access these life-saving drugs due to financial constraints and patent restrictions, a situation exacerbated by global health financing dynamics (Krikorian and Torreele 2021). This disparity became so entrenched within global health discourse that differential access to life-saving medicines based on geography and economic status was often framed as an unfortunate but inevitable reality, rather than a fundamental violation of the right to health (Ooms, Latif et al. 2013). The delayed and uneven distribution of these medications reinforced a broader pattern wherein economic and policy-driven constraints dictate health outcomes rather than the severity of health crises. Additionally, persistent disparities exist in health research and development priorities, for example, tropical diseases like schistosomiasis or guinea worm disease. Despite affecting millions, they are often classified as “neglected tropical diseases” – a term that reflects both the lack of medical attention and their systematic exclusion from global health financing priorities (Viergever 2013). Most recently, the COVID-19 pandemic has shown these disparities with unprecedented clarity. While wealthier nations rapidly secured vaccine doses for their populations, many countries in Africa and other historically marginalised regions faced significant delays, not due to logistical constraints or lack of infrastructure, but due to the financial and contractual power dynamics embedded in global health governance.

This entrenched architecture does not merely perpetuate inequities but actively reinforces them, making systemic disparities increasingly difficult to dismantle. The recurrent underinvestment in health infrastructure within historically oppressed regions fosters a persistent dependence on external aid, leaving these communities vulnerable to health crises. As health challenges intensify under these constraints, they inadvertently reinforce damaging stereotypes regarding the capacity for self-sufficiency of affected regions, portraying them as inherently unable to manage their own health challenges. Such portrayals become naturalised within global health discourse, where structural disadvantage is reframed as inherent incapacity, thereby obscuring the political and economic choices that create and maintain these disparities. This represents not merely a matter of health, but rather a system deliberately established decades ago that continues to shape contemporary global health outcomes.

Consequently, this article seeks to trace the historical origins of these inequities, examining how global health governance frameworks have been intrinsically shaped by colonial-era philosophies and financial architectures. By critically interrogating the legacy of European colonialism, with particular attention to Africa, whilst drawing comparative insights from Asia, our research aims to uncover the ways in which structures rooted in historical racial prejudices and economic exploitation continue to dictate present realities. The colonial project in Africa represents a particularly instructive case for understanding contemporary global health inequities. The systematic extraction of resources, dismantling of indigenous health systems, and imposition of racialised hierarchies during the colonial period have established patterns of dependency and marginalisation that persist within current health financing mechanisms. The Berlin Conference of 1884-1885, which formalised the partition of Africa among European powers, exemplified how health and well-being of colonised populations were subordinated to extractive economic interest, a dynamic that continues to echo in contemporary donor-recipient relations and health priority setting processes. Rectifying these structural flaws requires fundamental shifts in governance models, financing priorities, and decision-making structures to build a more just and equitable global health system.

After delineating the historical contours of inequity, it is equally imperative to examine the contemporary landscape in which digital health apps and technologies are rapidly advancing. As global health evolves, emerging technologies carry the risk of perpetuating colonial dynamics through data extraction and the reinforcement of systemic disparities. While promising

to revolutionise healthcare, these technologies do not occur in a vacuum. They unfold within the fabric of the global health financing structures previously outlined, structures still carrying the imprint of colonial-era power dynamics. It is within this context that the present article scrutinises the emergence of digital health solutions and their financing, recognising that without deliberate intervention, these advancements may unconsciously mirror historical inequities.

The article proceeds as follows: Section one historicises health inequities by examining colonial health systems across Africa and their racialised foundations. Section two traces the transition from colonial to contemporary global health inequities, analysing how international financial institutions perpetuate these power asymmetries. Section three examines how COVID-19 has exposed and exacerbated these structural disparities, particularly in vaccine distribution and fiscal response capacities. Section four explores the emerging realm of digital health technologies and their potential to entrench new forms of exploitation through data colonialism. The article concludes by arguing for a fundamental restructuring of global health governance to dismantle these persistent colonial legacies. We examine the colonial legacy within formal multilateral institutions: the WHO, World Bank, and IMF, as these represent direct institutional continuities from colonial governance structures. While private philanthropic actors undoubtedly influence global health, their analysis requires different theoretical frameworks that exceed the scope of this article.

Historicising Health Inequities

It has been argued that the historical legacy of European colonialism in Africa has left deep-rooted imprints on numerous facets of contemporary African societies, particularly in the realm of health systems (Cochrane 2022). This is seen from the establishment of health infrastructures during the colonial era, which was intrinsically interwoven with the racially charged ideologies of the colonisers (Ndege 2001). Therefore, it is crucial to critically analyse their motives and methodologies in order to better comprehend present-day disparities. The racial ideologies that pervaded the colonial period were not passive beliefs but actively informed the strategies and approaches of European powers in Africa (Mahmud 1999). Many European colonisers, driven by a sense of racial superiority, believed in their civilising mission, asserting that they were bringing progress and development to “backward” societies (Ndege 2001; Conklin 1997). This perceived sense of superiority

shaped colonial health policies, driving efforts to establish medical infrastructures that primarily served European settlers, while systematically neglecting the healthcare needs of the native populations.

Observations were made that serve as a poignant extension of this argument, reiterating that the colonisers' methodological flaws were rooted in racial biases (Harrington 2015). Their frequent dismissal and systematic undermining of traditional African medicinal practices dismissing them as "primitive" or "unscientific," speaks to their deep-seated ethnocentrism. Instead of seeking a collaborative integration acknowledging the merits of indigenous knowledge, they opted to impose a Eurocentric medical model. This choice, while strategic, sowed lasting seeds of disparity. Building on this narrative, the scholarship of Peter Duignan and Lewis Gann (1973) examined the establishment of health systems with the overarching imperialistic strategy during the late 19th and early 20th centuries. They underscore that Africa was predominantly perceived through an extractive lens, thus viewed as a reservoir of untapped resources awaiting exploitation. The colonisers, motivated by both racial superiority and economic ambitions, sought to harness Africa's riches. Against this backdrop, the present article argues that the health infrastructures that were established were not just influenced by racial ideologies, but also functioned as mechanisms to sustain and facilitate resource extraction. Healthy European workers, administrators, and settlers were essential to maximise the exploitation of Africa's natural resources. Thus, health systems, while overtly showcasing a facade of development, subtly perpetuated a cycle of racial hierarchy and systematic exploitation, leaving a lasting legacy of inequality and systematic exploitation in post-colonial African societies.

For instance, in Kenya, the inception of the colonial health department in 1920 had little to do with the welfare of the indigenous population (Beck 1970). Instead, its primary function was to shield the European settlers from tropical maladies such as malaria (Ndege 2001). Rather ironically, these settlers viewed the native Africans, who had lived in harmony with their land for millennia, as mere vectors of disease (Ndege 2001). While the Europeans sought refuge in well-established health facilities, healthcare services for the indigenous population were sparse and relegated to rudimentary care in remote mission stations (Latif 2019). The draconian segregation laws further accentuated this disparity, forcing Africans into congested reserves, away from European settlements, conditions that significantly heightened their health vulnerabilities.

A similar narrative unfolded in Nigeria. Britain's primary interests lay in harnessing Nigeria's abundant resources and maintaining an efficient local workforce. To this end, the establishment of a health system was not driven by humanitarian concerns but instead was instrumental, aimed more at preserving economic interests than fostering community welfare (Abubakar et al. 2022). While stringent quarantine laws ensured that no epidemic disrupted the mining and production sectors, the overall health infrastructure remained skeletal at best. Hospitals, scarce and unevenly distributed, primarily catered to British functionaries and a select few local elites, leaving the general population largely neglected. Likewise, Zimbabwe witnessed a health infrastructure largely tailored to bolster its burgeoning mining industry and the European agrarian settlements. Africans were forcibly displaced from their ancestral lands by rampant land grabbing, and confined to native reserves where the only semblance of healthcare came from missionary-run clinics (Makambe 1994). Meanwhile, in urban centres, modern and well-furnished hospitals were established, exclusively catering to the white settlers. In stark contrast, the rural clinics, aimed primarily at the indigenous population, functioned ideally to ensure a steady supply of healthy black labour for the colonial enterprise.

Looking into Algeria, previously under French rule, the narrative was not different and largely consistent with broader French imperialist strategies. The French colonial administration, focused on promoting settler agriculture and crafted health policies that overwhelmingly favoured the white farmers. Arabs and Berbers were subjected to an array of stringent health laws, from quarantines to mandatory vaccinations, all primarily designed to preserve the health of the settlers (Clark 2016). The divide between the settlers and the indigenous population was vividly reflected in the access to healthcare. The settlers enjoyed access to state-of-the-art hospitals, while the natives were relegated to rudimentary mobile clinics.

Shifting to Southeast Asia, in Burma and former Malaya, the British colonial narrative, although geographically distinct, followed similar patterns. As waves of Indian labour migrated to these regions, it became increasingly evident that their health was not just a matter of humanitarian concern but intertwined with economic imperatives. While Burma's bustling factories and Malaya's expansive plantations depended heavily on Indian labour, the establishment of the health sector was more about ensuring the continuity of this labour force than genuinely addressing their health concerns (Kaur 2006). The racial dynamics at play ensured that the Indian labourers, despite their critical contributions, were marginalized within the colonial health matrix.

Across these diverse colonial contexts, whether in Africa or Southeast Asia, the establishment of health systems was not an act of colonial benevolence. It was, more often than not, a strategic move, driven by racial prejudices and economic ambitions. The health of the indigenous and migrant populations was directly tied to their utility in the colonial machinery, and their welfare was considered secondary to the overarching imperial objectives. These cases reveal that the very establishment of these systems was marred by the racial prejudices of the time, which positioned Europeans as inherently superior and Africans as inferior and, more detrimentally, as carriers of diseases (Tilley 2016). As a result, in order to ensure the health preservation of European settlers, strict health measures such as quarantines, mandatory vaccinations, and even unsanitary settlements were enforced on the African populace (Vaughan 1991). For example, Southern Rhodesia in 1930 enacted legislation that African workers undergo medical examinations and vaccinations before entering urban areas, whilst no such requirements existed for Europeans travelling through the same spaces; a practice that framed African bodies as inherently diseased and dangerous (Valentine 2017).

This dual standard was evident throughout the established colonial medical systems. It has been demonstrated by Ann Beck (1970) that, while European enclaves had sophisticated medical facilities and swift responses to health threats, African settlements had to make do with rudimentary services, which were more focused on ensuring they remained productive workers rather than genuinely healthy individuals. The blatant racism of the colonial era was evident in the vast discrepancies in health spending. Minor outbreaks among the European populations triggered immediate and extensive interventions, whereas large-scale epidemics in African communities were dismissed as natural occurrences rather than humanitarian crises that required urgent action. Furthermore, the introduction and imposition of Western bio-medical models often side-lined and belittled indigenous medical practices and knowledge (Illiffe 1998). Instead of harnessing local expertise and attempting to integrate indigenous and Western practices for a holistic healthcare approach, colonial health policies were characterised by a top-down, coercive approach.

Beyond the establishment of health systems, the attitudes and strategies employed in their deployment were exemplified by the broader colonial ethos. Europeans' self-proclaimed civilisational superiority not only guided economic and political policies but also deeply influenced sectors like healthcare. What was promised as the spread of "civilisation" was, in fact,

the imposition of a racially biased system that viewed healthcare not as an intrinsic right for all, but as a tool of control and differentiation (Latif 2023). While many African nations have since attained political independence, the shadows of their colonial pasts still loom large, especially in sectors like healthcare. The systems and policies, originally crafted with racial biases, have frequently persisted, requiring modern African nations to grapple with these legacies as they strive to create health systems that are truly inclusive and equitable. In essence, the colonial health systems of Africa, while draped in the rhetoric of welfare and development, were in reality reflections of the racial prejudices of the era.

An analysis of the historical legacy of European colonialism in Africa reveals severe disparities in health finance, highlighting how colonial priorities hardly extended to the well-being of the indigenous populations. This disparity is evident in the case of Kenya, where the colonial health department was established not as a mechanism for indigenous welfare but as a strategic means to protect European settlers from diseases. This racially charged approach resulted into a lack of investment in the health of the native population. The colonisers left health financing predominantly in the hands of local native councils (Ndege 2001), reflecting their blatant disregard for the well-being of the African communities. The colonial emphasis on economic exploitation over humanitarian concerns resulted in a systemic imbalance in health funding. While the European enclaves benefited from well-funded and technologically advanced medical facilities, the indigenous settlements were left with meagre resources and severely underfunded clinics (Cavanagh and Veracini 2017).

This financial divide was a direct consequence of the colonial agenda, which viewed the health of the native population as secondary to maintaining a productive workforce for their economic interests. Thus, the colonial legacy of inadequate health financing remains an enduring challenge for modern African nations striving to address historical injustices and create equitable health systems. Moreover, global health finance today, to a significant extent also reflects the biases and structures established during the colonial period. The contemporary global health financing ecosystem is multifaceted, composed of diverse actors including governments, multilateral agencies, bilateral partnerships, non-governmental organisations (NGOs), private sector entities, and philanthropic foundations. Each stakeholder operates within defined governance structures bringing its own strategies and priorities, thus influencing how resources are allocated and which health issues receive prioritisation on a global scale. This complex ecosystem is

often characterised by systemic power imbalances and funding streams that reinforce longstanding disparities; patterns can be seen as reflections of a colonial mindset. The next section examines this in greater detail.

A Transition from Colonial to Global Health Inequities

Whilst the previous section examined how colonial health systems embedded racial hierarchies within national contexts, this section traces how these same logics of domination were reconstituted at the global scale through post-war financial institutions, transforming explicit racial segregation into ostensibly neutral economic governance mechanisms that nonetheless perpetuate colonial power asymmetries.

The foundation of today's Global Financial Infrastructure (GFI) reflects a post-World War II era, distinguished by the creation of the International Monetary Fund (IMF), the World Bank Group, and the General Agreement on Tariffs and Trade (GATT), which later evolved into the World Trade Organisation (WTO) (Barr 2014). Designed in response to the financial crises of the 1930s and informed by the protectionist barriers that arose during the Great Depression, the Bretton Woods Conference established institutions whose objective was to liberalise trade. John Maynard Keynes (2019 [1919]) played an instrumental role in crafting this vision, which was primarily centred on economic stabilisation, reconstruction, and growth.

However, beneath the progressive rhetoric of these institutions lay inherent flaws. It is evident that while these institutions were framed as universal platforms for economic cooperation, their operations were deeply entrenched in the imperialistic ambitions of the dominant Western powers. In his seminal work "Kicking Away the Ladder: Development Strategy in Historical Perspective," Ha-Joon Chang provides a nuanced critique of these international financial institutions. He contends that developed nations, after having benefited from various protectionist measures during their own developmental phases, now advocate for free-market policies in developing nations, effectively "kicking away the ladder" that they themselves had used to climb to prosperity (Chang 2004). This perspective is widely viewed as an extension of imperialistic ambitions, where former colonial powers, through these financial institutions, seek to maintain their dominance and continue extracting value from their former colonies.

The IMF, World Bank, and WTO operationalise Western hegemony through three distinct mechanisms. First, Structural Adjustment Programs (SAPs),

implemented across numerous developing countries during the 1980s and 1990s, mandated aggressive liberalisation and privatisation reforms that eroded local industries and dismantled public welfare systems, including health and education. Second, voting rights determined by financial contributions ensure that wealthier, predominantly Western nations maintain disproportionate influence over the decision-making processes. Third, Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreements advance multinational corporate interests whilst hindering the access of developing nations to essential medicines and the ability to develop indigenous industries. Despite purporting to serve a broad coalition of economies, the decision-making authority within these institutions remains concentrated. The fact that both the IMF and World Bank decision-making was heavily influenced by contributions from member states, with the USA's unprecedented economic size allowing it the largest voice, meant that policies and financial decisions often mirrored Western, especially American, interests (Barr 2014).

This standardisation operates through specific institutional mechanisms: the IMF's macro-economic conditionalities impose uniform fiscal policies regardless of local contexts; the World Bank's project financing prioritises infrastructure models developed for Western economies; and the WTO's trade regulations entrench comparative advantages established during the colonial period. Each mechanism reinforces the fiction that Western development trajectories represent natural economic evolution rather than historically contingent paths shaped by colonial extraction. The marginalisation of nations in Africa, Asia, and even Latin America underscores the racial architecture of these institutions, where non-Western countries often found their voices diminished, reinforcing economic hierarchies rooted in colonial legacies (Hickel et al. 2022).

This bias reflects deeper issues of transnational accountability and global economic legitimacy. The structural bias raises crucial questions about equitable representation and the fundamental legitimacy of these institutions. Thus, what appears as technical economic governance masks the continuation of colonial power relations through financial means: a shift from direct political control to structural adjustment, from racial segregation to market segmentation, from civilising missions to development discourse. As long as decision-making authority remains concentrated in the hands of economically dominant nations, the global financial architecture will continue to reflect and perpetuate the entrenched disparities inherited from colonial-era governance.

Global Health Governance

Translating these financial and political imbalances into the realm of global health reveals a landscape rife with disparities. For instance, although the WHO's prioritisation of diseases with pandemic potential is essential for global health security, it may also evoke feelings of colonial-era policies that prioritised the protection of European settlers over the health of local populations. This dynamic is codified legally in the International Health Regulations (WHO 2005)), which focus on preventing the international spread of disease, mirroring the quarantine laws of the colonial period (Fidler 2004). Additionally, whilst the WHO operates on a one-country-one-vote principle, the organisation's dependence on voluntary contributions creates a *de facto* influence for wealthy donors who can earmark funds for specific priorities, thereby overshadowing the voices of less affluent countries, despite their formal voting equality, a structure that perpetuates colonial governance patterns. In the realm of resource allocation, the pattern of directing funds towards specific disease-focused vertical programmes creates parallel health systems that often serve urban elites who can access specialised clinics, whilst neglecting the comprehensive primary healthcare infrastructure needed by rural and marginalised populations. This mirrors the colonial approach that established sophisticated medical facilities for European settlers whilst providing only rudimentary services for indigenous populations (Mackey 2013).

The global health law also reflects these disparities, particularly in the protection of intellectual property rights in agreements such as the Trade-Related Aspects of Intellectual Property Rights (TRIPS). TRIPS have been criticised for favouring pharmaceutical companies in high-income countries at the expense of accessible healthcare in the global south ('t Hoen 2009). Moreover, imposing universal guidelines without adequate consideration of local contexts may reinforce a one-size-fits-all approach, thereby marginalising indigenous knowledge. Emergency response and international aid, often framed as humanitarian assistance, can sometimes create dependencies that echo the paternalistic civilising missions of the colonial powers, instead of empowering local health systems (Ndege 2001). In addition, the sometimes-lack of cultural competency in some health interventions harks back to the colonial dismissal of local customs, which were critical to community health practices.

Furthermore, global health is shaped not only by natural epidemiological factors but is intertwined with the policies and priorities of global financial institutions. For instance, health programs funded by the World Bank often reflect the health priorities of the Western countries, side-lining pressing

health challenges endemic to regions such as Africa or Asia. Consequently, countries may be pressured to adopt Western health financing models that do not align with their unique socio-cultural and economic contexts. Such a misalignment risks creating health systems that fail to address the unique needs of their populations, thereby potentially widening health disparities. For instance, donor countries may earmark funds for high-profile diseases such as HIV/AIDS, tuberculosis, and malaria, which although undeniably critical can overshadow basic healthcare services, maternal health, and non-communicable diseases that increasingly burden low-income regions. This situation may perpetuate dependency, as recipient countries adjust their health agendas to conform to donor preferences, a dynamic that mirrors the colonial economic systems in which local economies were restructured to serve the interests of the colonisers. This is in line with the concept of structural violence, which can be understood as the systematic ways in which social structures harm or disadvantage individuals.

As Paul Farmer (2023) demonstrates, structural violence embedded in global economic policies, predominantly influenced by the West, exacerbates health inequalities, especially in resource-limited settings. This violence manifests itself through various global health financing mechanisms. Whilst initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and GAVI, the Vaccine Alliance, represent significant efforts to channel funds towards targeted health crises, their vertical approach reveals another dimension of structural violence. These funds, despite achieving success in addressing specific crises, may contribute to fragmented health systems by bypassing national frameworks and creating parallel structures that undermine the sovereignty of domestic health policy planning. While the present article focuses primarily on Africa as representative of the Global South's experience, it is essential to recognise that these patterns of structural violence extend beyond the African continent. Allan Lumba's work on the Philippines, for instance, demonstrates how racial capital – the process through which racial difference is produced and valued to facilitate capital accumulation – operated within colonial structures to produce similar outcomes in Southeast Asia, revealing the transnational character of these exploitative frameworks (Lumba 2022). Indeed, the architecture of health inequity transcends simple geographical binaries of Global North versus South.

In conclusion, the colonial imprints are not confined solely to national governance and economic structures; they have also bled into global health governance. Despite their universal mandates, global health institutions frequently mirror colonial-era power dynamics. Decision-making processes,

the allocation of funds, the determination of health priorities, and research orientations are often dominated by these historically dominant nations. This unfortunately means that global health agendas often prioritise the interests of these dominant nations over the urgent needs of the most vulnerable populations. Thus, while many global health initiatives are praised for their ambitious scope, they often, perhaps unintentionally, reinforce and perpetuate the very inequities rooted in colonial-era practises. The design and operation of these institutions often result in systems in which financial and knowledge-based resources disproportionately flow towards priorities that align with the interests of historically dominant nations. Consequently, the most pressing challenges faced by historically marginalised communities are systematically sidelined in global health agendas and global health decision-making.

Global Health Disparities following COVID-19

While the World Health Organization (WHO) and the World Bank appear to function as democratic multilateral entities, the concentration of power operates through different mechanisms in each institution. In the WHO's case, despite its one-country-one-vote system, the dramatic rise in extra-budgetary contributions, now comprising over 80% of its budget, allows wealthy donors to earmark funds for specific priorities, effectively bypassing democratic decision-making. The World Bank, conversely, formally embeds this power imbalance through voting shares tied to financial contributions. Both mechanisms marginalise voices from low- and middle-income countries whilst fundamentally eroding the principles of global partnership. Furthermore, this asymmetry extends beyond governance to fiscal matters. Wealthy nations, often descendants of former colonial powers, tend to maintain a disproportionate control over global health funding. This dominance frequently skews global health priorities often giving privilege and attention to diseases that predominantly affect high-income nations while marginalising health concerns that disproportionately impact lower-income nations.

This pattern reflects colonial days when the interests of the colonisers were prioritised over the colonised. For instance, the past neglect of certain tropical diseases, which, despite their significant prevalence in low-income regions, have historically received minimal attention and funding (Ndege 2001). Similarly, in the realm of Research and Development, a critical sector, research and development are significantly dominated by high-

income countries of the global North. Wealthy countries, leveraging their superior research infrastructure and financial resources, dictate the medical research agenda, often prioritising diseases and technologies aligned with their interests. A clear example of this disparity emerged during the COVID-19 pandemic of the early 2020s, when vaccine development and initial distribution were heavily concentrated and monopolised by richer nations, leaving many poorer countries dependent on external mechanisms and aid for supply access (Stevano et al. 2021).

The global health landscape, historically entrenched in systemic inequalities, remains deeply fragmented, raising urgent concerns about equity. The intersection of health disparities and entrenched financial hierarchies illustrates the persistent structural barriers that impede equitable global health outcomes. In this regard, Philip Alston (2020) in his report on poverty eradication, examines the pervasive nature of poverty and illuminates the entrenched contours of global health inequities. By framing global health within the broader “existential crossroads,” including pandemics, economic instability, and movements against systemic racism, Alston affirmed the need for a more profound scrutiny of these structures. Beyond exposing vulnerabilities in health systems, the COVID-19 pandemic served as a critical reflection of broader failures within the global economic order. It became a mirror reflecting the fragility and exploitative nature of contemporary capitalist structures. Whereas prior crises of the century were rooted predominantly in financial collapses, COVID-19 emerged as a multifaceted crisis, underlining the interconnectedness of health, economic, and social sectors. Its disproportionate impact on marginalised communities affirmed the enduring inequalities within global capitalism (Stevano et al. 2021).

At the core of these exploitations lie colonial-era structures, which persist under the guise of modern capitalism. The very systems that govern our world, though technologically advanced and globalised, continue to embody enduring inequities rooted in colonial legacies. Moreover, the pandemic prompted a reconsideration of the state's role, revealing that states must act not merely as facilitators of economic activities but as direct agents in shaping equitable responses to crises. Wealthy countries swiftly deployed expansive fiscal interventions, while nations in the Global South, constrained by historical debt burdens and financial dependency, faced limitations widening the pre-existing gap between Global North and South. The inequality became painfully evident in the vaccine distribution crisis, with wealthy nations securing disproportionate shares of vaccine stocks, reinforcing the broader inequities embedded in global capitalism (Ning et

al. 2022; Li et al. 2021; Oxfam 2020). This systemic imbalance is neither accidental nor temporary. It reflects the entrenched biases within global financial architecture, prioritising profit-driven motives over human welfare.

The catchphrases for COVID-19 mitigation, “stay home, socially distance, wash hands,” exposed deep inequities in global pandemic preparedness and response. For those cushioned by affluence, these directives may seem minor inconveniences. However, for countless individuals entrenched in poverty, they were not merely difficult but nearly impossible to adhere to. How does one socially distance in overcrowded slums? How does one regularly wash hands without reliable access to clean water? Far from serving as the “great leveller,” the pandemic widened the gap between the privileged and the marginalised. The pandemic laid bare the systemic neglect of those living on the fringes of prosperity (Alston 2020). It is within this context that the structural biases of the global financial system demand scrutiny. To reiterate, the post-colonial world order, built upon structures established by the Global North, has not only inherited economic hegemonies but also actively sustains them, continuing the legacies of extraction and exploitation (Latif 2019). These structures operate across multiple dimensions, through trade policies, intellectual property laws, and debt mechanisms, prioritise financial accumulation over equitable health access. They are not the passive results of global economic development but, in many ways, emblematic of an architecture rooted in racist ideologies and Eurocentric paradigms.

From a financial standpoint, the pandemic further exposed the disparity in available resources for health emergencies. Western countries, with their considerably larger economies, were able to quickly mobilise vast financial reserves to cushion the impact of the crisis. The contrast was also evident in government spending; for instance, the United States passed relief packages totalling trillions of dollars (Sheth and Zeballos-Roig 2021), and the European Union established a €750 billion recovery fund (Boffey and Rankin 2020). In contrast, many African nations, weighed down by historical debt and limited fiscal autonomy, found it challenging to mobilise similar levels of resources. Even when international bodies such as the IMF and World Bank provided emergency financial assistance, the aid often fell short in comparison to the self-financed large-scale stimulus packages of the West.

The financial constraints faced by African nations had direct and severe implications for health disparities. While Western nations rapidly scaled up their health infrastructure, implementing mass testing, expanding

hospital capacity, and securing medical supplies, African nations struggled to obtain basic diagnostic kits during the early phases of the pandemic. The disparities became even more pronounced with the rollout of vaccines and the distribution. Prior procurement agreements ensured that wealthier Western countries secured billions of doses, effectively stockpiling vaccines for their populations (United Nations 2021). In contrast, many African countries became heavily reliant on the COVAX initiative, a global effort to ensure equitable access to vaccines. However, COVAX struggled with supply chain constraints and was unable to meet demand adequately. As of mid-2022, while many Western countries had achieved substantial vaccination coverage, a significant portion of the African population remained unvaccinated due to supply constraints and logistical challenges. Furthermore, the pandemic's economic fallout disproportionately impacted African nations. Many African economies, heavily dependent on tourism and commodity exports, saw their revenue streams dwindle, furthering the pre-existing financial instability. In contrast, many Western countries, benefitting from diversified economies and substantial stimulus packages, began showing signs of economic rebound far more quickly.

The COVID-19 vaccine apartheid represents not a departure from but a continuation of colonial medical segregation. Just as colonial health systems reserved advanced medical treatments for European settlers whilst subjecting African populations to experimental vaccines and substandard care, the pandemic response replicated these racial hierarchies on a global scale. The mRNA vaccine technology, developed with significant public funding and global scientific knowledge, became the exclusive property of Western pharmaceutical corporations through patent monopolies, which is a modern iteration of colonial resource extraction where knowledge and innovation from the Global South contribute to technologies they cannot access. When African nations requested temporary patent waivers to produce vaccines locally, they faced the same paternalistic arguments once used to deny colonies industrial development: concerns about “quality control” and “technical capacity” that masked the real intent to maintain technological dependence. This deliberate creation of scarcity through intellectual property regimes mirrors colonial strategies of artificial famine and resource hoarding, transforming life-saving vaccines into instruments of geopolitical control that reinforce the colonial fiction of Western benevolence delivering “aid” to the “helpless” Global South, rather than acknowledging how structural barriers prevent equitable access to commonly-held human knowledge (Uddin 2021).

The narrative of global inequities, especially within the framework of fiscal capacities and health disparities, paints a tale of two different worlds. In one, the gleaming hospitals of high-income nations stand tall, bolstered by strong fiscal capacities that give them the edge in times of crisis. The Global North, with its expansive coffers and access to low-interest loans, is not just financially affluent but also medically privileged. When pandemics strike, these nations rapidly deploy resources in order to bolster their medical infrastructure and launch vast public health campaigns. Yet, travel a little south, and the picture becomes markedly different. The Global South, with its constrained financial autonomy and inadequate safety nets, grapples with a dual challenge. On the one hand, there is the immediate health crisis, demanding funds, resources, and attention. On the other, there is the looming shadow of long-term economic instability. For these nations, borrowing constraints are more than financial hurdles, they reflect entrenched global disparities in health access. In essence, they face a grim dilemma to either prioritise urgent health interventions or safeguard future economic stability; a choice no country should be forced to make.

This stark division is not merely economic. It is fundamentally structural and deeply rooted in historical power dynamics. As John Harrington (2015) elucidated, these disparities are manifestations of systems designed during colonial times, with their primary purpose being to serve colonial interests rather than to promote equitable health outcomes. The contemporary financial architecture, while ostensibly more inclusive, nevertheless perpetuates these historical biases, frequently prioritising the interests of wealthier nations over addressing the pressing health needs of poorer countries. Crucially, the COVID-19 response has highlighted the urgent need for what David Fidler (2004) terms a “post-Westphalian” approach to global health governance, one that transcends state-centric models and acknowledges the interconnectedness of global health challenges.

The pandemic also exposed what Ellen 't Hoen (2009) described as the “intellectual property paradox” in global health. While Intellectual Property Rights protections are essential for innovation, they can also impede access to essential health technologies. This was evident in debates over vaccine patents, where the needs of pharmaceutical companies were often prioritised over the imperatives of global health equity. Additionally, the pandemic highlighted the consequences of what Tim Mackey (2013) identified as the fragmentation of global health governance, with various entities often working in silos rather than in coordinated fashion. This fragmentation mirrors colonial-era divisions and undermines efforts to address health crises comprehensively and equitably.

Ultimately, as Sara Stevano et al. (2021) argue, the COVID-19 pandemic has underscored not just health inequities, but also the broader crisis of global capitalism, which continues to prioritise profit over people. The pandemic demonstrated starkly how existing financial architectures, with their roots in colonial institutions, exacerbate rather than alleviate health disparities. Moving forward requires what Chang (2004) would describe as a fundamental reimagining of the global economic order one that does not simply offer the Global South a chance to climb the existing ladder, but reconstructs the ladder itself in order to ensure equitable access to health resources regardless of a nation's economic status or colonial history.

Global Health, Digital Health Apps, and International Finance: Initial Analysis

The persistent global health inequities rooted in historical structures have found new expression in the realm of digital health, particularly through the development of health apps amid widespread digitalisation and the COVID-19 pandemic. At the height of the pandemic, the disparity in funding allocation for health apps revealed a divide reminiscent of colonial-era power dynamics. Wealthy nations, leveraging their considerable resources, were able to rapidly develop and implement technologies for tracking and tracing the virus. In contrast, as Kevin Kavanagh et al. (2021) have shown lower-income countries faced significant challenges not merely due to lack of apps but because of structural barriers: limited digital infrastructure, inadequate technical capacity for app development, insufficient data governance frameworks, and a dependence on foreign technology platforms, all legacies of colonial underdevelopment that prevented autonomous technological responses to the pandemic.

Beyond their immediate public health function, these health apps became instruments that inadvertently mirrored the extractive practices of colonialism through asymmetric data flows. Just as colonial powers extracted raw materials from colonies for processing in metropolitan centres, these apps collected vast amounts of behavioural, location, and health data from users in the Global South, which flowed to servers controlled by technology companies in the Global North, where the data was processed, analysed, and monetised without meaningfully benefit-sharing with the source communities (Aouragh et al. 2020). While initial investments in these technologies were driven by the urgency of the pandemic, a creeping but significant concern now emerges: the extensive data amassed by these apps

(Wongsin et al. 2022). The management and control of this data raises fundamental ethical and governance concerns because of data sovereignty: the right of nations and peoples to govern their own data is systematically undermined when health information is stored in foreign jurisdictions, subject to foreign laws, and controlled by foreign corporations, creating new dependencies that echo a colonial-era loss of sovereignty over natural resources. This foreshadows the emergence of a new variant of colonialism: data colonialism (Couldry and Mejias 2019). This emerging form of exploitation mirrors historical colonial patterns, as control over health data is disproportionately concentrated in high-income countries, often without equitable benefit to, or consent from, the populations of lower-income countries who are the subjects of the data (ibid.).

Data colonialism actively exacerbates global health disparities by enabling the continuation of unequal power dynamics. High-income countries can leverage this data to strengthen their healthcare systems and advance economic interests, thereby reinforcing their dominant positions. Conversely, lower-income nations, already marginalised by the digital divide, face further exclusion and are denied access to the benefits and insights extracted from the health data of their own populations. This situation widens the gap in global health outcomes, as data increasingly becomes the new commodity for perpetuating existing inequities and perpetuating international imbalances.

This emerging data paradigm must be contextualised within the broader historical patterns of extraction that have characterised North-South relations. As Stefania Milan and Emiliano Treré (2019) argue, these digital asymmetries constitute a continuation of longstanding patterns of appropriation, where resources now in the form of data flow predominantly from the Global South to the North. During the pandemic, this manifested concretely: contact tracing apps such as Singapore's Trace Together were adapted by Western technology firms, who then deployed modified versions across Africa and Asia, collecting location and proximity data from millions of users. Google and Apple's exposure notification framework, while presented as a public health tool, required countries to route their citizens' health data through American-controlled infrastructure (Lee and Lee 2023). The commodification of health data, particularly from vulnerable populations, without adequate consent mechanisms or benefit-sharing frameworks, represents what Michael Kwet (2019) has termed "digital colonialism." For instance, health screening apps deployed at African airports collected biometric and health data that was stored on Amazon

or Microsoft cloud servers, creating technological dependencies where countries could not access or control their own citizens' health information without paying licensing fees to Western corporations thereby reinforcing historical power imbalances through digital means (Blume 2022).

The collection and utilisation of health data through digital apps raises significant concerns about ownership and sovereignty, particularly regarding who controls the data, who profits from it, and who decides how it is used. When citizens in Kenya or Nigeria use COVID-19 symptom checkers or vaccination verification apps, their health data often becomes the property of foreign technology companies through terms of service agreements written under U.S. or European law, effectively stripping individuals and nations of sovereignty over their most intimate information. Nick Couldry and Ullises Mejias (2019) describe how data extraction operates through seemingly benign technological interfaces that mask underlying power dynamics. Within health contexts, this often manifests as surveillance systems ostensibly deployed for public health monitoring but effectively functioning as mechanisms of data accumulation that privilege external actors over local communities.

During the pandemic, thermal scanning systems installed across African airports by Chinese and European companies collected not just temperature readings but facial recognition data, movement patterns, and health histories, creating databases controlled by foreign entities whilst local health ministries received only limited aggregate reports. Digital vaccine passports required by international travel systems forced African nations to upload their citizens' vaccination records to platforms controlled by Western technology consortiums, creating a situation in which accessing their own citizens' health data required paying licensing fees to foreign companies (Lyon 2022). This structural arrangement reflects what Lyla Latif (2024) identifies as "algorithmic colonialism," whereby technical systems encode and reproduce existing hierarchies of power and privilege.

These parallels with historical colonialism are not merely metaphorical but represent substantive continuities in how resources and power are distributed globally. As Shoshana Zuboff (2019) observed, digital technologies often reinforce rather than disrupt colonial patterns of knowledge production, particularly when the technical expertise and infrastructure for data analysis remain concentrated in wealthy nations. Within health contexts, this frequently results in the Global South serving primarily as data sources rather than equal participants in the production of health knowledge and

innovation. For instance, genomic data collected from African populations during COVID-19 variant surveillance was predominantly analysed in European and North American laboratories, with African scientists often excluded from resulting publications and patent applications despite providing the biological samples. Machine learning algorithms trained on health data from diverse Global South populations are developed by Silicon Valley companies who then sell these AI-powered diagnostic tools back to the very communities whose data trained them, at prices that extract value whilst providing minimal local benefit. African researchers frequently find themselves reduced to data collectors for Western-led studies, gathering information that is analysed abroad and published in journals they cannot afford to access. This creates a perverse cycle where the Global South provides the raw materials: health data, that fuel innovation and profit generation in the Global North, whilst being excluded from both the knowledge production process and its economic benefits, precisely mirroring colonial relations when raw materials were extracted for value addition elsewhere (Jansen and Auerback 2023).

The COVID-19 pandemic accelerated these trends, as the rapid deployment of digital health solutions often occurred without adequate attention to issues of data governance and equity. Governments and private corporations in high-income countries rapidly developed digital contact tracing applications and vaccine passport systems, frequently with limited consideration of their potential implications for digital sovereignty or privacy, particularly in contexts with limited regulatory frameworks (Wongsin et al. 2022). This pattern mirrors historical approaches to health interventions in colonised regions, which frequently imposed external models with minimal adaptation to local contexts or considerations of long-term sustainability.

The absence of robust international frameworks governing health data flows further compounds these inequities. Unlike physical resources, which are subject to various international agreements regarding extraction and compensation, data operates in a regulatory vacuum that privileges those with the technical capacity to extract and analyse it. This regulatory asymmetry reinforces what Zuboff (2019) described as “surveillance capitalism,” wherein the unequal extraction of behavioural data from marginalised populations serves as a primary mechanism of value creation and accumulation. For lower-income countries, this frequently creates impossible choices between participating in potentially exploitative data relations or being excluded from the benefits of digital health innovations altogether.

Thus, future research stemming from this work will critically examine the governance of health data and address the structural mechanisms that sustain data control while perpetuating the legacies of colonialism. By interrogating these exploitative dynamics and advocating for more equitable governance of health data, there exists an opportunity to transition away from data colonialism and toward an ethically just model of data distribution. International finance plays a decisive role in either reinforcing or dismantling these inequities. It offers the potential to reconfigure global health equity. Without the constraints of its current colonial undertones, it can serve as a catalyst for transformative change, one that prioritises transparency, democratic decision-making, and the sovereign control of health data by lower-income nations.

A reimagined framework for health data governance must incorporate principles of data justice, ensuring that the collection, analysis, and application of health data serve to reduce rather than reinforce existing inequalities. This requires significant reforms to international financial institutions that currently shape digital health investment patterns. The World Bank, regional development banks, and bilateral donor agencies must integrate robust data rights frameworks into their funding mechanisms for digital health initiatives, ensuring that investments in technical infrastructure are accompanied by investments in local data governance capacity.

Furthermore, private capital flows into digital health must be subject to greater scrutiny and regulation, particularly when targeting lower-income regions. Without appropriate safeguarding, private investment in digital health can replicate extractive models that prioritise commercial interests over public health needs. International finance institutions have a critical role to play in establishing standards and incentives that promote equitable data partnerships rather than exploitative ones. The development of local technical capacity represents another crucial dimension of addressing data colonialism in health. As technical resources for developing digital health solutions remain concentrated in high-income countries, lower-income nations often have little choice but to adopt externally developed systems that may embed foreign values and priorities. Targeted financial support for indigenous innovation in digital health, coupled with technology transfer mechanisms that prioritise local ownership and control, can help address these structural disparities.

As we look toward the future of digital health in a post-pandemic world, the path we choose will determine whether these technologies serve as tools of emancipation or instruments of continued exploitation. By critically

examining the colonial legacies embedded within current approaches and actively working to dismantle them, we can harness the transformative potential of digital health to create a more equitable global health landscape, one in which all communities have meaningful agency over their health data and equitable access to the benefits it generates.

Conclusion

This article has demonstrated how colonial-era health inequities persist in modern global health financing and governance, shaping disparities that disproportionately impact the Global South. The historical examination reveals that health systems established during colonial rule were designed primarily to serve European interests rather than indigenous populations, creating structural biases that continue to influence contemporary global health architecture. These biases manifest themselves in present-day power imbalances among global health actors, resource allocation priorities, disease focus, and institutional decision-making processes. The transition from colonial to post-colonial structures has not fundamentally altered these power dynamics, as international financial institutions such as the IMF and the World Bank replicated colonial hierarchies through governance mechanisms that privilege wealthy nations. These structural imbalances have tangible consequences for health outcomes, evident in the stark disparities in health spending, life expectancy, and access to essential services between high and low-income regions. The COVID-19 pandemic of the early 2020s has further revealed these injustices, showing how financial architectures rooted in colonial legacies have widened the gap between wealthy and poorer nations in health response capabilities, vaccine access, and economic recovery.

As digital health technologies gain prominence, there exists a significant risk of perpetuating exploitative dynamics through data colonialism. Without deliberate governance frameworks, health data collected from marginalised populations may be extracted without equitable benefit-sharing, replicating historical patterns of resource exploitation. The commodification of health data without adequate consent mechanisms or sovereignty protections represents a contemporary manifestation of colonial extraction in digital form. Addressing these deeply entrenched inequities requires more than incremental reform. Global health governance must be fundamentally restructured in order to ensure equity, transparency, and the meaningful representation from historically disadvantaged regions. This includes

elevating marginalised voices in decision-making processes, redirecting financing toward a comprehensive health system strengthening rather than vertical interventions, and establishing ethical frameworks for digital health governance that prioritise data sovereignty and equitable benefit-sharing.

Only through consciously decolonising global health governance structures, by redistributing power, resources, and decision-making authority, can we begin to dismantle the persistent inequities that shape global health outcomes. This requires not merely acknowledging historical injustices but actively reconstructing international financial frameworks to serve the needs of all populations equitably, independent of their economic status or colonial history. The path toward global health equity demands nothing less than a fundamental reimagining of how health resources, knowledge, and power are distributed across our interconnected world.

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