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How do we "decolonize Global Health"?

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Abstract

A raft of recent commentaries has called for the "decolonization of Global Health." "Global Health" commentators concerned with medical education, practice, research and governance would appear to agree that the status quo is grossly inequitable. They suggest that embedded power asymmetries rooted in the colonial past persist and that they are a major barrier to reducing inequity. A range of actions has been suggested as steps toward addressing these power imbalances such as ensuring funding panels are more representative and distributing the majority of resources and leadership roles, toward the affected geographies and communities. In this manuscript, we share our view on what both "decolonization" and "Global Health" might mean, and outline some key actions to combat racism in health research and practice.

Keywords:

Decolonization, global health, health research, medical education

What is Global Health?

It's difficult to pinpoint exactly when "Global Health" was introduced as a capitalized proper noun. An editorial from 1991 proposed that this term be adopted to replace "International Health," which was widely used at the time to describe the activities of U.S. and European academics and international organizations involved in supporting the development of health research and health systems in low-to-middle income countries (LMICs).[1] "International Health" was itself a re-branding of "Topical Medicine" and "Colonial Medicine," focusing primarily on infectious and tropical diseases, and maternal and neonatal health in LMICs.[2] In some commentaries, the "Global" in "Global Health" is interpreted very much in a geographical sense, offering definitions such as "health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people,"[3] or "health issues where the determinants circumvent, undermine or are oblivious to the territorial boundaries of states, and are thus beyond the capacity of individual countries to address through domestic institutions."[4] Other commentators suggest that "Global Health" is a distinct departure from this: they suggest that "Global" refers to the "scope of problems" and not their geographical location. This therefore includes a much broader range of disciplines (including noncommunicable diseases, aging and mental health etc…) and is not restricted to action in LMICs.[5] This broadening results in incredibly cumbersome definitions such as "an area for study, research, and practice that places a priority on improving health and achieving health equity for all people worldwide."[5] This has been shortened to "collaborative trans-national research and action for promoting health for all,"[6] but it is still an incredibly vague and all-encompassing definition. Has health research and action not always been primarily about promoting health for all? What differentiates "Global Health" from simply "Health"? What would constitute "non-Global Health"?

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These cumbersome definitions are well-intentioned, but they skirt around the elephant in the room: Simply re-branding "International Health," does not alter underlying structures, such as how research is funded, or which institutions set the agenda. Whilst there have been noticeable recent improvements in attitudes and acceptance that the current system is inequitable, the lack of structural and institutional change means that the term "Global Health" remains stuck as nothing more than a pseudonym for the terms it was introduced to replace. It is an uncomfortable truth, but to many people, even if only sub-consciously, "Global Health" means "the health of poorer or browner people." It is white gaze viewing the health of "them" as opposed to "us." For this reason, every time we say "Global Health" (or write it, as we do many times in this article) we re-enforce people's stereotypes, prejudices and biases. We group together the diverse health problems, cultures and host genetics of most of humanity, and make an academic discipline out of studying "them." There is no corresponding discipline which groups together the diseases of white-Europeans. In Zambia (for example), there is no "Lusaka School of Hygiene and Temperate Medicine," where research groups specialize on noncommunicable life style-induced disease, cancer, cardiovascular, and neurodegenerative diseases.

Re-branding is both costly and pointless without deeper change, but institutions, departments, journals and courses which currently use "Global Health" in their title could consider why they use this term and what they mean by it. The term "Low-to-Middle Income Countries" (LMICs) also seems stigmatizing and ambiguous. The World Bank defines "LMIC" as countries with a GNI per capita ≤$4095. Therefore LMIC includes 82 countries, in Southern and Central America, Africa, South Asia, Central Asia and South East Asia. What statement can you make that is true of all these countries and their diverse populations? Whatever our health discipline, we should be engaging with and working equitably with others in the world who are working in the same field. In this sense, we should all be working "Globally." "Health Equity Research" has been suggested where the specific research focus is on inequity in health,[7] and it would seem logical to bring gender and tribe/caste to join race under this banner, as there are many parallels united by the underlying psychology of bias and prejudice. But any superficial change of name, should not be at the expense of meaningful structural change to address the root causes which sustain inequity.

What is "Decolonization"?

The "decolonization of Global Health" has been defined as "a movement that fights against ingrained systems of dominance and power in the work to improve the health of populations, whether this occurs between countries, including between previously colonizing and plundered nations, and within countries."[8] This mirrors the kind of wordy definitions that have been offered for "Global Health." Some authors are even deliberately against offering a normative definition of what it means to "decolonize Global Health," citing the need to keep the movement flexible and accessible to those outside of academia.[2] But how can we discuss what we want to do, and how we want to do it, without clear and universally understood definitions?

Is decolonization primarily a racial concept? Do historically rooted power imbalances relating to gender, class and tribe/caste fit into this movement, or do they need their own movements? The U.K. has an expansive and deeply amoral colonial history, with power imbalances and racial bias persisting to the current day. In a recent response to this, many U.K. universities have established "decolonization" committees, and are looking at how they can decolonize the curricula and educate their staff and students about racial bias.[9] In the U.S., a similar approach is being taken with respect to Critical Race Theory, and there is a growing popular understanding that we all have deeply rooted racial biases.[10] There is criticism of these approaches on both sides: On the political right they argue that there is no need for these interventions, and that complaints about racism are largely unfounded. Conversely, on the political left, they argue that the measures being rolled out (things like implicit bias training, or recruitment policies, rules and targets), are tokenistic and about perception and virtue signaling.[8,11]

The "Global Health" agenda is set by the leaders of a network of universities and research institutions which are predominantly in Europe and North America. This perpetuation of the colonial dimension of agenda setting in "Global Health" discourse is a key barrier to progress. Whilst the lower ranks of personnel in these institutions are becoming more diverse, this is often used as a "photo op" to virtue signal that the right changes are taking place. Yet leadership positions are still dominated by people of white-European ancestry and among them, there is a disproportionate weighting toward the privately educated. Promotions are primarily awarded for "grant income won," "papers published" and "peer esteem," all metrics which are biased toward well-networked privately educated white-Europeans.

This racial dominance is also embedded into the very business models of these institutions, who are keen to recruit international students, because they pay up to twice as much as home students. Not only do international students have to pay higher course fees, but they are also lumbered with extortionate fees for visas

and health insurance/access, along with the other costs associated with international re-location. This system selects for wealthy students from among the ruling elites in LMICs, sustaining domestic power-imbalances, that might relate to tribe or political groups. Where scholarships are available, corruption (including in HICs) erodes the meritocracy of these schemes, sustaining inequity further.[12]

There have been several articles published recently which discuss decolonization, highlighting some of the practices that perpetuate inequity and discussing a range of useful actions to get us moving more swiftly in the right direction.[2,8] At face value, a lot of the proposed solutions seem both sensible and achievable, such as having more representation of LMIC scientists on funding panels and in leadership positions, or having more resources and decision-making powers located in LMIC institutions. One model that has been widely used to try (or feign) to re-distribute power, is to establish a large base in a LMIC. These organizations are often registered "locally" as independent entities with a "local" board of directors, but these "outpost" organizations are typically hugely dependent on the parent HIC organization for core funding, which comes with many strings attached. Whilst many of these organizations have delivered quality research and provided opportunities for training among junior personnel, there have been controversies about equal opportunities to career advancement and differential salaries between expatriate (immigrant) and "local" personnel.[13]

What is the role of nonwhite people in decolonization? Are we to nod approvingly as another implicit bias training workshop kicks off? What about our biases? Should we attend the training also? What is the role of LMIC governments, institutions and scientists in decolonization? One of the largest forces sustaining the power imbalance is money. Most research in LMICs is funded by European and U.S. donor agencies.[14] Whilst some funders have made efforts to give LMIC scientists direct access to research funding, the vast majority of European and U.S. research funders primarily support collaborations with European and U.S. institutions, who often take a disproportionate share of the budgets.[14] To try and shift the balance of power, one of the most beneficial things that LMIC governments could do, is to invest more in domestic programs of scientific research funding. Many LMIC governments focus on health education[15] and healthcare service provision, because there is little political capital to be gained in funding research. More national funding would give complete control over the research process to LMIC institutions.[16]

If we are going to meaningfully "decolonize," then it would be extremely useful to establish a definition of what this means, and some universal metrics by which we might measure our impact in this endeavor.[17] For health researchers, a common metric of equity could be authorships, but authorship positions are ambiguous and anyone who has done a reasonable amount of publishing knows that the biggest lie in science is the phrase "all authors contributed equally." Grant funding is another possible metric, but this would only inform on equity for senior personnel and PIs, and would not capture inequity within junior personnel. For measuring people's subjective experiences there are various racial discrimination tools that have been developed and evaluated.[18] These are useful internal tools for institutions to monitor their current status and identify areas for improvement, but they don't allow real time monitoring of discrimination globally, or comparison between institutions.

Conclusions

Whilst there is a broad consensus that "Global Health" needs to change, the idealistic goal of a perfectly equitable system is unrealistic. A level playing field of this nature occurs in no-other realm of human endeavor, outside of the idealistic utopian imaginations of socialist revolutionaries. But this does not mean we can't make things better. The authors of this commentary believe that to help decolonize our minds and the way we work, we should consider the following key proposals:

1. The term "Global Health" could be phased out, as it is synonymous with the colonial terms it has replaced and therefore sustains a "them" mentality which homogenizes disparate nonwhite European populations
2. "Equitable Health" could be used to describe researchers whose specific focus is on inequity in health
3. Institutional decolonization actions should be meaningful and not just virtue signaling
4. A consensus should be established on how to objectively measure the impact of efforts to decolonize health research/practice, and academia more broadly
5. All students, irrespective of their nationality or race, should pay the same fee for the same course.

International collaboration in health research is hugely beneficial, with diverse expertise and experience coming together to design and implement studies that advance our understanding of health challenges, leading to improved health outcomes.[19] "South-South" partnerships and networks are expanding,[20,21] with organizations like the Asian-African Society for Mycobacteriology (based in Tehran) promoting LMIC research networks, which are more independent of European and North American "centers of excellence." The lead role of the Africa CDC in the continent's widely

admired response to the COVID-19 pandemic is evidence of the strong South-South partnerships and networks that already exist.[22,23]

Despite the many inequities and challenges highlighted in this commentary, there are many positives, and the vast majority of heath researchers are broadly united behind efforts to combat racism and decolonize. We are all prejudiced by deep-seated sub-conscious bias with respect to race and identity. Whilst completely ridding ourselves of this most human of traits is unrealistic, developing a culture where we are more open about it, and taking bold action to address and fix glaring inequities, would be simultaneously taking small steps and giant leaps toward a brighter and more equitable future.

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Conflicts of interest

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