Decolonising Global Health: What does it mean for Asia?

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Webinar Report

Panellists

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Moderator

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Jointly organised by:

SingHealth DukeNUS Academic Medical Centre – Global Health Institute
St. Luke's Medical Center College of Medicine – William H. Quasha Memorial
The Aga Khan University – Institute for Global Health and Development
BRAC James P Grant School of Public Health
HKU Med – LKS Faculty of Medicine, The University of Hong Kong 香港大學李嘉誠醫學院
Mahidol University – ASEAN Institute for Health Development

The ***Decolonising Global Health: What does it mean for Asia*** webinar was jointly organised by the SingHealth Duke-NUS Global Health Institute, Planetary and Global Health Program**,** St. Luke's Medical Center College of Medicine, The Aga Khan University, Institute for Global Health and Development, BRAC James P Grant School of Public Health, Li Ka Shing Faculty of Medicine, The University of Hong Kong and ASEAN Institute for Health Development, Mahidol University. The webinar aimed to bring together leaders from various institutions across Asia to examine the evolving discourse around decolonising global health in educational institutions and ways in which Asia can help 'decolonise' global health within and beyond the region.

Ms Amina Mahmood opened the webinar by presenting statistics from the Global Health 50/50 report, titled Power, Privilege and Priorities, which highlights that 85% of global organisations who are active in health and health policy are head quartered in Europe and North America, 80% of global health leaders are nationals of high income countries (HICs) and 92% obtained their degrees in HICs. She initiated the discussion by posing a question on what role Asia can play in changing these statistics at various levels - national, global, regional and personal.

Dr Renzo Guinto saw the importance of the webinar as an opportunity to understand what Asians think about decolonising global health and expressed his hopes that the discussions and activities around the topic in Asia continue to grow. He provided a brief introduction to the many ways in which the term decolonisation can be interpreted or defined; challenging western superiority and hegemony, the reversal of colonial legacies and return to indigenous practice and believe systems or recognising pluralistic knowledge systems. He highlighted his decision to return to work in Southeast Asia as an act of decolonisation and emphasised the need for decolonisation to take place at the individual level, institutionally in education and practice and regionally.

"I see my journey as a young emerging global health and planetary health scholar practitioner to be an act of decolonisation" – Dr Renzo Guinto

Dr Sabina F. Rashid reflected on key drivers that perpetuate power and privilege in global health and which have led to the valuing of specific types of knowledge in curricula, research standards, spaces and voices. She challenged the exclusive value placed on knowledge from specific geographic locations and highlighted how we are socialised to assume and accept these as our knowledge base. She asked:

- How do we move away from labels such as 'local' vs 'global'? Global being seen as geographic spaces that are considered knowledgeable and local as geographic spaces with an absence of knowledge that need "capacity".
- How do we create a space for diversity and inclusion and pay attention to new voices and priorities that are not always counted or are counter narratives to discourses?
- What are the gold standards in research that we are socialised to accept and what are the systemic barriers that make it difficult to question these standards?

Dr Vivian Lin highlighted the need to understand three key dimensions, relating to structure, agency and context, when thinking about change and engaging in decolonising global health conversations. She pointed to the complex history and world order many global health institutions of today reflect and how the knowledge base of global health continues to reflect the dominant Anglo-American research funding and publication channels.

She further pointed out how the finance of many institutions reflect the wealth that had been created in the period of 19th century imperialism and present day global capitalism. Dr Lin highlighted the distinctive characteristics of Asia and the reasons why Asian institutions find themselves at the margins - linguistic diversity, inward focus on national identity and nation building and the lack of global power.

"When we talk about decolonising GH, what are we talking about? Is it to turn away from worshipping the US and the UK? Is it to understand our own history, culture and practices better...Is it to strengthen to our regional institutions for shared learning and comparative analysis? What is our vision? " – Dr Vivian Lin

Dr Zainab Samad started by unpacking what global health is in the present day - highlighting the interconnectedness of the world and the shift in science to take a global perspective to tackle challenges like COVID-19 and climate change. She explained that the unequal challenges in health and well-being are driven mainly by power and resource asymmetries and defined decolonising global health as addressing these asymmetries and levelling the playing field. She reflected on the alignment of Aga Khan University's mission to this definition by being responsive to the identified needs of communities and the region it serves and to promote access and equity. She also emphasised the need to think about how institutions across Asia, keeping equity as a core value, can network and share learnings while being sensitive to not become neo-colonisers themselves.

Dr Phudit Tejativaddhana echoed other panellists by highlighting the need for organisations and institutions to come together to solve global health issues. He emphasised that health equity needed to be the guiding principle around which to think about how to decolonise global health. He also highlighted the need for global health technologies and knowledge to be localised and for local knowledge to be heard and acknowledged globally. He concluded by calling for equitable partnerships, collaborative leadership and capacity strengthening and the need for global health security as a common priority for the region.

Ms Mahmood started the panel discussion by asking the panellists whether the agenda of decolonising global health can be separated from the broader political agenda in public health and how one can work within the power structures and with local elites. Dr Rashid responded by highlighting the work of BRAC's leaders and colleagues in implementing community based experiential learning - bringing in indigenous knowledge and focusing on implementation science to embed learning in the community within the curricula. She emphasised the need to be courageous and have strong leadership to expand beyond the global public health space; she underscored the importance of leaders assuming the responsibility of calling out practices that do not sit well with their values. Dr Samad highlighted the interconnectedness of health with politics and economics and points to Pakistan's effective response towards COVID -19 as an example where different stakeholders came together for a united response to socially and fiscally protect the community.

Moving to the topic on global health education, Ms Mahmood posed a question on how Asian education systems can be reimagined and redesigned to be recognised internationally. The panellists pointed to systemic barriers that might prevent this shift and suggested ways in which it can be initiated. Dr Lin emphasised that education is the medium through which people are socialised to ideas and ways of thinking and strengthening the education initiatives across the region through sharing of lectures and student exchanges will be key. She also highlighted that these can be hard to achieve given the global imperatives, such as global university rankings and journal impact factors, that education institutions are working under.

Dr Guinto echoed this point and highlighted that it would be key to leverage current technology to create more virtual classrooms across countries. He called for the reinvention of the content in global and public health education through these three Vs:

- Re-examine the vision of global health – Is it a homogenous and universal vision that is coming from one corner of the world and is not inclusive of other people's vision??
- Re-examine the vocabulary of global health – Can the language and narrative created around words change?
- Re-examine the values – Is there room for other types of Asian values?

He also emphasised the need for more faces and voices from Asia to be role models for future Asian GH leaders.

Dr Rashid highlighted the importance of critical reflection on what we are socialised to value and the need to constantly take steps to improve curriculums. Dr Samad highlighted the importance of developing and articulating thoughts and case studies from Asia in curriculums to sensitise people to the issues while ensuring that the conversation did not leave out experts from different sectors. She also highlighted the need to include diverse curriculum creators to have more Asian voices reflected in the curriculums. Dr Tejativaddhana provided an example from Mahidol University's initiative to steer away from adapting curriculum from Western sources for their PHD students and moved towards interactive learning where study units were formed by local experts and practitioners on the ground.

Ms Mahmood extended the previous question on education to the topic of research and sought thoughts on how research agendas and what is valued in research can be changed. Dr Samad broke down the key areas in research and publication that often need to be negotiated by practitioners in low and middle income countries (LMICs): authorship, funding, allocation of resources and co-creation.

On authorship, Dr Rashid cited the skewed numbers in publications from colleagues in HICs and questioned the value placed on certain formats and knowledge in research - highlighting how certain types of on the ground knowledge are often lost due to their lack of fit into the standard publication formats. She emphasised the need for waivers, subsidies and action from boards to curb privileges that accrue to specific voices in research due to the costs involved in publishing. Dr Guinto echoed this and highlighted the need for publications to start exploring new ways to present data and findings to make it more inclusive. He further highlighted that journals still lack the involvement of academics from the global south and reiterated the need for those governing these platforms to be diverse and inclusive.

On research funding and allocation of resources, Dr Guinto emphasised the need for global health funding to be given to LMIC based institutions and also for colleagues in LMICs to push their own governments to invest in global health research.

On co-creation and collaboration, Dr Rashid emphasised the need for research to be embedded in contextual realities. She highlighted that while there are measures in place to ensure data ownership and data autonomy and ensure that colleagues from LMICs do not become mere data collectors, there is also a need to invest in capabilities to ensure that they capable of engaging in the work needed.

Delving further into the topic of equity in partnership, Dr Tejativaddhana highlighted that the concepts of fairness, equity and the 'no one left behind' need to be at the heart of partnerships. He emphasised the need for defining the roles and responsibilities of stakeholders and understanding and

compensating for the inequalities present to enable all partners to benefit from the partnership. Dr Rashid added that part of ensuring equity in partnership involves risk-taking - the courage to say no to partnerships that perpetuate the cycle of inequity and negotiating to ensure that partnerships are balanced and based on mutual understanding.

Ms Mahmood asked what can be done to ensure that leaders in global or public health, who are trained in the West, remain in or return to the region. Dr Rashid responded by emphasising the need to remove hierarchies in institutions and create systems and policies that encourage spaces for mid-level faculty and researchers to have opportunities to engage and have ownership. Dr Guinto highlighted the need for role modelling and ensuring that there is an enabling environment in terms of reward, finance and access. He also addressed the importance of finding allies and colleagues who are on the same boat to share the journey with.

Addressing an audience question on how to ensure that one is not side lined when taking on certain stances, Dr Rashid echoes Dr Guinto's thoughts on creating allies within institutions and beyond. She emphasised the importance of being strategic about pushing agendas and arguments to showcase the longer term benefits and engagement.

"Be strong in your beliefs and not shy away from those conversations" – Dr Sabina Rashid

To wrap up the webinar, each panellist covered how global health institutions can be held accountable for pursuing this agenda.

Dr Tejativaddhana stated that working together will be very important in creating collaboration and finding like-minded people to come together to reach the goals that have been set.

Dr Lin stated that there is a need to look at the different types of institutions and different approaches to accountability. She highlighted the prominent presence of funding from private institutions and the lack of accountability that comes along with it. In terms of multilateral collaborations, she pointed out that the evolving framework around civil society engagement and research institution monitoring could be strengthened and more conversations around the framework convention on global health could be held.

Dr Samad highlighted three keys points for accountability. The first being able to articulate the issue though different mediums, second having open platforms for conversations generating accountability within institutions engaged in these conversations and third to expand the inward looking lens within countries to all of Asia. She hoped that more global health institutions will engage in conversations in the future.

Dr Rashid echoed the sentiments of the rest of the panel that accountability is complicated but it should not stop everyone from being vocal about it in different spaces while creating more spaces for such dialogue to take place. She highlighted that by sharing alternative or competing curriculums that are gold standards, it creates a healthy environment for scrutiny, reflection and accountability, allowing institutions to fill in on gaps and unmet needs.

Dr Guinto stated that the sibling of accountability is reflexivity. He called for the need of reflexive practices both from the side that is held to account and from those holding them accountable. He highlighted that many global organisations are having difficult conversations internally on systemic

structures like hiring practices and from Asia as a region there is a need to reflect on what our motives, visions and interest are so that in our pursuit of decolonising we do not become neo-colonisers.

Ms Mahmood closed by calling on everyone to reflect on their willingness to take risks, to look at the systems and structures that need to change and reflect on their own privileges. She ended the webinar by posing a challenge to everyone in the audience:

"In the next three months, challenge yourself to do something that helps this path of decolonising Global Health"

Send us your own reflections on decolonising global health and what you have done or are doing to decolonise global health to sdghi@duke-nus.edu.sg.