Re-imagining Global Health Training: Experiences from UCLA and UCT in South Africa

World Congress of Epidemiology (WCE), Cape Town, South Africa
25 September 2024

Dr. Dvora Joseph Davey
Associate Professor of Infectious Diseases and Epidemiology
University of California Los Angeles, USA
Honorary Associate Professor, Division of Epidemiology & Biostatistics
School of Public Health, University of Cape Town, South Africa

School of Public Health
Departement Openbare Gesondheid
Isikolo Sempilo Yoluntu
UNIVERSITY OF CAPE TOWN

UCLA Fielding School of Public Health

UCLA David Geffen School of Medicine

Positionality statement*

I am a US-born, white, cis-gender, educated woman who lives in South Africa with my South African family.

- I acknowledge the systems and structures which afford my unearned privilege.
- I am committed to improving my understanding and practice around decolonizing research, guided by feminist and deconolizing perspectives and by people with lived experiences different than my own.

*Help us to be aware of our perspectives, beliefs and underlying assumptions in our work, including our biases.

The Equality Institute | Why positioning identity matters in decolonising research and knowledge production: How to write a ‘positionality statement’

Can you imagine this?

Two MPH students from University of Cape Town in South Africa land in Los Angeles for a 2-week visit.

They visit the campus and talk to some professors, visit some local organizations & schools to learn more about gun violence on campus, and read a few reports.

They write up a report with recommendations on how to fix gun violence in the US.

They publish their paper in the *American Journal of Public Health*

Hard to imagine, right?

Reimagining global health: Why?

- Global health keeps failing on equity
- Key reason: the field is inequitable
  - Global North & privileged actors hold power
- To bring equity, global health must evolve **from saviorism to allyship**
- Many obstacles to shifting power, but it is possible
- But, no change happens without a demand

Why & how is global health structurally inequitable?

The art of medicine

Will global health survive its decolonisation?

There are growing calls to decolonise global health. This process is only just beginning. But what would success look like? Will global health survive its decolonisation? This is a question that fills us with imagination. It is a question that makes us reflect on what Martin Luther King Jr saw when he said in 1968, in the last speech he gave before he was killed, that "I've been to the mountaintop...and I've seen the Promised Land." If what he saw was an equal, inclusive, and diverse world without a hint of supremacy, then, that world is still elusive. Similarly, an equal, inclusive, just, and diverse global health architecture without a hint of supremacy is not global health as we know it today.

What we know as global health today emerged as an enabler of European colonisation of much of the rest of the world. It has since taken on different forms—for example, colonial medicine, missionary medicine, tropical medicine, and international health—but it is yet to shed its colonial origins and structures. Even today, global health is neither global nor diverse. More leaders of global health organisations are alumni of Harvard than are women from low-income and middle-income countries (LMICs). Global health remains much too centred on individuals and agencies in high-income countries (HICs).

A future in which global health is decolonised would be one in which there are no longer pervasive supremacist remnants of colonisation within global health practice. But how do we imagine such a world? The calls for equity and justice in global health practice need to be matched with a bold vision of the future. What vision can global health practitioners rally around and work towards? As the struggle for equity and justice continues, those in power are likely to fight back—or respond with evasions, token concessions, and changes in appearance but not in substance. Perhaps, a clear vision of what equity and justice looks like can help global health practitioners overcome such inadequate responses.

To decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level. Supremacy is not restricted to White supremacy or male domination. It concerns what happens not only between people from HICs and LMICs but also what happens between groups and individuals within HICs and within LMICs. Supremacy is there, glaringly, in how global health organisations operate, who runs them, where they are located, who holds the purse strings, who sets the agenda, and whose views, histories, and knowledge are taken seriously. Supremacy is seen in persisting disregard for local and Indigenous knowledge, pretence of knowledge, refusal to learn from places and people too often deemed "inferior", and failure to see that there are many ways of being and doing. Supremacy is there in persisting colonial and imperialist (European and otherwise) attitudes, in stark and disguised racism, White supremacy, White saviourism, and displays of class, caste, religious, and ethnic superiority, in the acquiescing tolerance for extractive capitalism, patriarchy, and much more.

Indeed, supremacy persists in the ways of seeing and assumptions that underpin global health practice. It is a supremacist way of seeing and doing when we entertain implicit hierarchical assumptions—for example, about the headquarters of a global health organisation being more important than its regional or country offices. Supremacy manifests in seeing the big as superior to the small—for example, in the focus on national governments when subnational governments are more consequential and closer to the ground. And supremacy is enacted when a greater value is placed on research by HIC or distant experts than the knowledge of those with lived experience.

Will global health survive its decolonisation? Perhaps. But only if its practitioners commit to its true transformation. A crucial first step is recognising that ours is a discipline that holds within itself a deep contradiction—global health was birthed in supremacy, but its mission is to reduce or eliminate inequities globally. To transcend its origins, global health must

Martin Luther King Jr (1929-68)

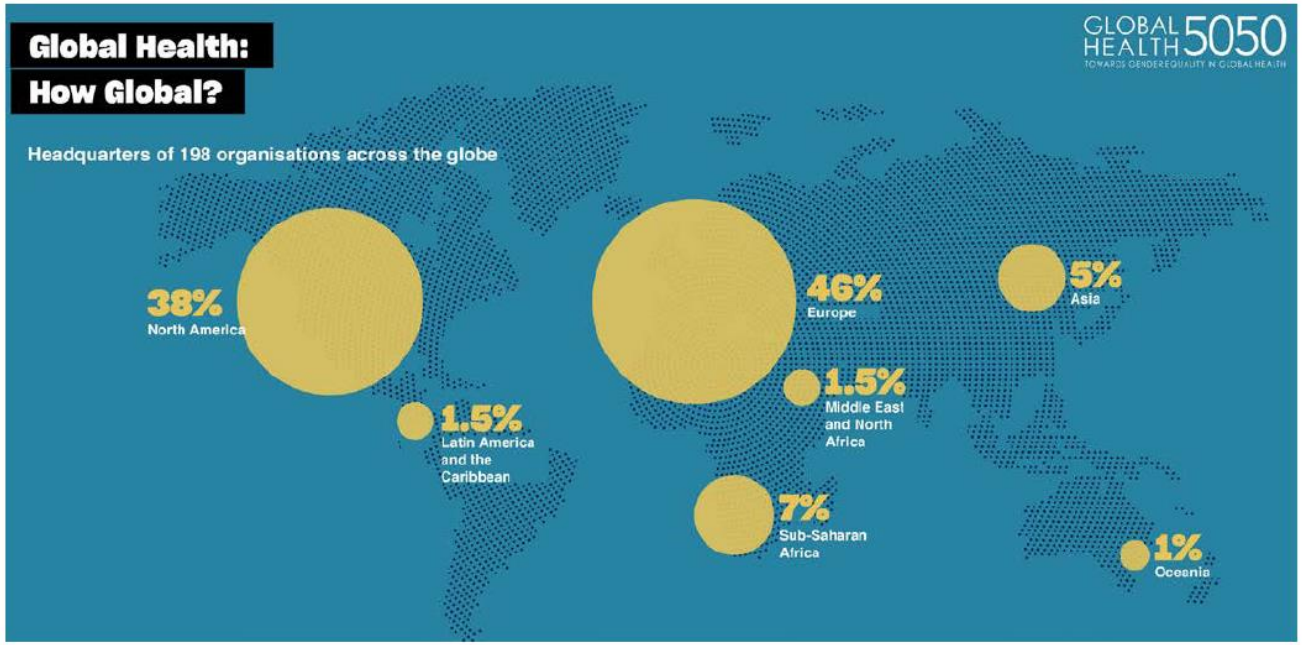
"Global health is a discipline that holds within itself a deep contradiction—global health was birthed in supremacy, but its mission is to reduce or eliminate inequities globally"

Abimbola & Pai, *Lancet* 2020

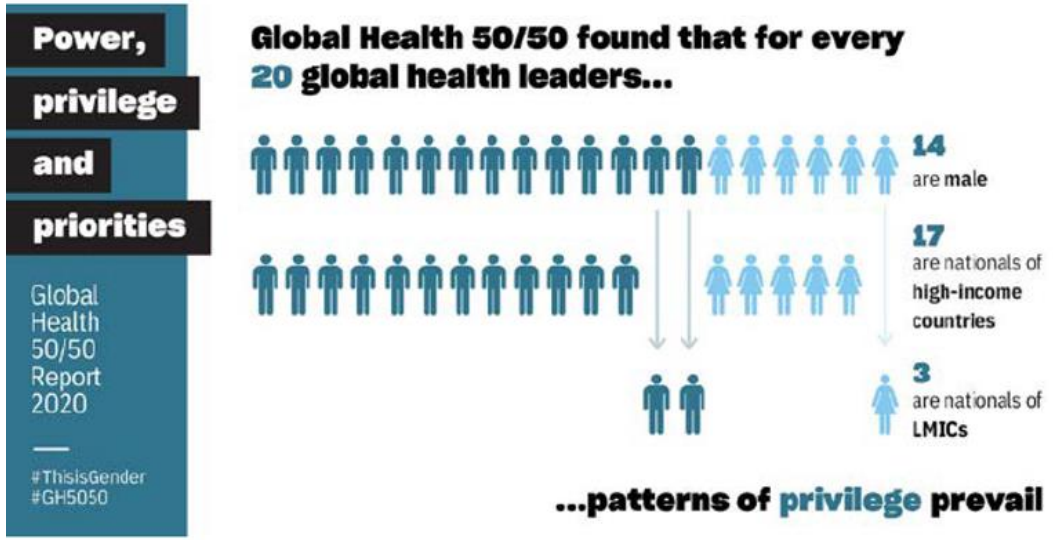
Slide from Prof. Madhukar Pai, McGill University

Will global health survive its decolonisation? - ScienceDirect

Where are the global health orgs?



Who are the leaders?



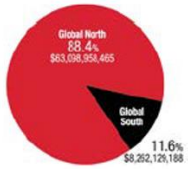
https://globalhealth5050.org/

Where does the $$ go?

70% of Fogarty grants go to US & HIC institutions

73% of the total int. grant portfolio supports UK-based activity

~80% of USAID's contracts & grants go to US firms



Slides from Prof. Madhukar Pai, McGill University

Dissemination of global health research

Who is publishing?

BMJ Global Health

Stuck in the middle: a systematic review of authorship in collaborative health research in Africa, 2014–2016

Bethany L Hedt-Gauthier ,[1] Herve Momo Jeufack,[2] Nicholas H Neufeld,[3] Atalay Alem,[4] Sara Sauer,[5] Jackline Odhiambo,[6] Yap Boum ,[7] Miriam Shuchman,[3] Jimmy Volmink[8]

BMJ Global Health

Authorship equity in global health research: who gets the credit at University of California, San Francisco?

Overall, 16% (n=948) of UCSF affiliated articles had a LMIC researcher as the first author, 19% (n=1,059) had an LMIC researcher as second, and 14% (n=820) as last author

review of authorship for infectious disease research conducted in Africa, 1980–2016

Rose Mbaye,[1] Redeat Gebeyehu,[2] Stefanie Hossmann,[3] Nicole Mbarga,[4,5] Estella Bih-Neh,[6] Lucrece Eteki,[7] Ohene-Agyei Thelma,[8] Abiodun Oyerinde,[9] Gift Kiti,[10] Yvonne Mburu,[11] Jessica Haberer,[12,13] Mark Siedner,[14] Iruka Okeke,[9] Yap Boum [7,15]

Who is editing?

PNAS

RESEARCH ARTICLE | SOCIAL SCIENCES

Non-White scientists appear on fewer editorial boards, spend more time under

In 27 global health journals—of 303 editors

- 40% were females
- 68% based in high-income countries
- 34% were based in Europe
- 30% were based in North America

Among editors-in-chief:

- 27% were females
- 73% were based in high-income countries.

Aidan Desjardins[6], Mayte Bryce-Alberti[7], Alejandra Castro-Varela[3], Parnian Khorsand[8], Ander Santamarta Zamorano[9], Laura Jung[10], Grace Malolos[11], Jiaqi Li[12], Dominique Vervoort[13], Nikita Charles Hamilton[14,15], Poorvaprabha Patil[16], Omnia El Omrani[17], Marie-Claire Wangari[18], Telma Sibanda[19], Conor Buggy[20], Ebele R. I. Mogo[21]

Commentary

Diversity in the editorial boards of global health journals

Soumyadeep Bhaumik [1], Jagnoor Jagnoor [1, 2]

Correspondence to Dr Soumyadeep Bhaumik; sbhaumik@georgeinstitute.org.in

https://doi.org/10.1136/bmjgh-2019-001909

PDF

XML

Where are conferences held & for whom?


'The concept of solidarity is a lie': Why these empty chairs at AIDS 2022 have Canada under fire

The Africa CDC chief had trouble getting into Germany for the World Health Summit

Attendees from poor countries often struggle to get visas to attend the conferences that discuss their future


Dr Githinji Gitahi, MBS
@daktari1

A 🟪 on @Amref_Worldwide solidarity withdrawal from in-person participation at the @H_S_Global conference in #Colombia due to systemic visa/passport discrimination of participants from the Global South

4:08 AM · Oct 25, 2022 · Twitter for iPhone


World view

'Exhausted and insulted': my EU visa ordeal

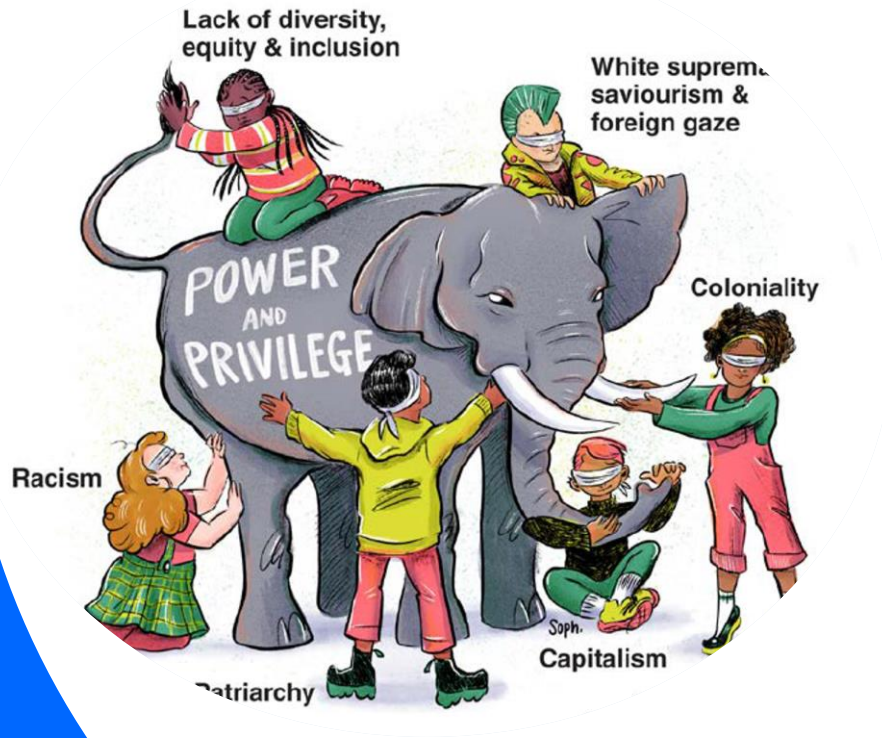
By Sandra Owusu-Gyamfi

My experience as an African researcher trying to travel to a conference in a wealthy country is sadly not an isolated incident.

Often, 22 were in Africa: see go.nature.com/3vxubai. These refusals come at a huge cost to individual researchers. Visa applications require scientists to be studious with

Slide from Prof. Madhukar Pai, McGill University

Global health & development



How the Global North likes it

- Charity, philanthropy
- Aid
- Donations
- Development assistance
- Saviourism
- Dependency

How the Global South wants it

- Human rights
- Equity and social justice
- Reparations
- Autonomy, respect
- Self-determination & self-sustenance

@paimadhu

Slide from Prof. Madhukar Pai, McGill University

What is the problem if the privileged dominate global health?

- We lack lived experience
- Our privilege prevents us from seeing things clearly
- We are away from the real problems and solutions
- We make mistakes (even if our intentions are good)
- We will center ourselves
- We can stop feeling generous (with no accountability)
- We may fail to address structural issues

Rethinking global health training

Can you re-imagine this?

Two MPH students from University of California land in Cape Town for a 2-week visit.

They visit the UCT campus and talk to some professors, visit some local clinics to learn more about HIV prevention, and read some reports.

They write up a report with recommendations on how to prevent HIV in South Africa.

They publish their paper in the *Lancet HIV*

This happens all the time!

What can global north actors do?

FORBES > INNOVATION > HEALTHCARE

Disrupting Global Health: From Allyship To Collective Liberation

Madhukar Pai Contributor ⓘ
I write about global health, infectious diseases, and equity

Follow

Mar 15, 2022, 02:31pm EDT

Updated Mar 16, 2022, 03:33am EDT

This article is more than 2 years old.

Health workers unity and global healthcare partnership as a group of diverse medics connected ...
[+] GETTY

What is allyship?

The Anti-Oppression Network defines allyship as "an active, consistent, and arduous practice of unlearning and re-evaluating, in which a person in a position of privilege and power seeks to operate in solidarity with a marginalized group."

The Anti-Oppression Network expands the above definition by stating:

- allyship is not an identity—it is a lifelong process of building relationships based on trust, consistency, and accountability with marginalized individuals and/or groups of people
- allyship is not self-defined—our work and our efforts must be recognized by the people we seek to ally ourselves with

Examples from the field... how do we learn together, as allies, to do better?

UCLA Global Health Program

"Improving health equity worldwide"

- UCLA's Global Health Program (GHP) at UCLA's School of Medicine creates *reciprocal, long-term* collaborations rooted in equity, trust, and mutual respect.
- Students, trainees, faculty, and staff work alongside colleagues around the world on multidisciplinary education programs, clinical training, patient care, research and public health initiatives.
- GHP prepares medical students and trainees to advance health equity by providing them with knowledge, skills, and structural competency in global health.

Nafisa Wara (3rd from left), UCLA MS3, Fogarty Intl & GloCal Fellow with UCT staff in qualitative training (Lara Court, Ringie Gulwa & Chwayita Ntwasa)

DAVID GEFFEN SCHOOL OF MEDICINE GLOBAL HEALTH PROGRAM

We believe health is a human right.

Experiences with bringing UCLA fellows & students to UCT

- UCLA to UCT Medicine & Epidemiology Global Health Program: >8 years experience (>20 students and fellows)
- They come in with great ideas and (usually good) intentions
- They have strong opinions or hypotheses they want to evaluate
- We give them access to UCT resources, people, time, data, and even go forward to collaborate on grants & publications
- Most students, faculty, researchers are excellent allies and work with our UCT partners on analysis, clinical work, or other initiatives
- Some are not prepared to be an ally and require more mentorship and support
- ***What can we do better in our collaboration and ensuring reciprocity for UCT learning and research?***

1. Equity in authorship


PLOS MEDICINE

OPEN ACCESS

EDITORIAL

Time to end parachute science

Beryne Odeny, Raffaella Bosurgi

/ersion 2 Published: September 6, 2022 • https://doi.org/10.1371/journal.pmed.1004099

Colonial science, also known as parachute or parasitic science, is an extractive practice whereby researchers—typically from highly resourced countries—do research and extract data and samples from non-native regions or populations, typically low resource settings or countries, [1] without appropriately acknowledging the importance of the local infrastructure and expertise. In so doing, foreign researchers fail to establish long term, equitable collaborations with local partners [2].

Examples

- *PLOS, Lancet and Cell Press* have policies to prevent parachute science & promote inclusivity in global research.
  - Foreign researchers are required to complete an "Inclusivity in global health questionnaire"—to improve transparency in reporting of research performed outside researcher's own country
  - *Lancet* rejects papers from Africa that fail to acknowledge African collaborators
- Royal Society of Chemistry: started a collective action & Joint Commitment for Action on Inclusion and Diversity in Publishing

Joint Commitment for Action on Inclusion and Diversity: https://www.rsc.org/new-perspectives/talent/joint-commitment-for-action-inclusion-and-diversity-in-publishing/

2. Striving towards *true* equity in global health training

PLOS GLOBAL PUBLIC HEALTH

PLOS Glob Public Health. 2023; 3(1): e0001418. PMCID: PMC10021183
Published online 2023 Jan 18. doi: 10.1371/journal.pgph.0001418 PMID: 36963065

Striving towards true equity in global health: A checklist for bilateral research partnerships

Daniel Z. Hodson, [1] Yannick Mbarga Etoundi, [2,3] Sunil Parikh, [1,4] and Yap Boum, II [5,6,7,*]

Abdisalan Mohamed Noor, Editor

1. Collaborators should prioritize locally derived & relevant solutions to global health issues.
2. Collaborations should be paired between HIC and LMIC at as many levels as possible (i.e. principal investigators, field teams, laboratory staff, trainees).
3. Budgets should provide for paired funding to investigators from both HIC and LMIC countries (e.g. bidirectional travel, conference attendance, dedicated research time).
4. Collaborations should mutually assign clear roles & responsibilities which value, leverage, and share the strengths of all team members and institutions.
5. These contributions must then be appropriately during the dissemination phase.

3. Advancing equity in global health during each pha of research:

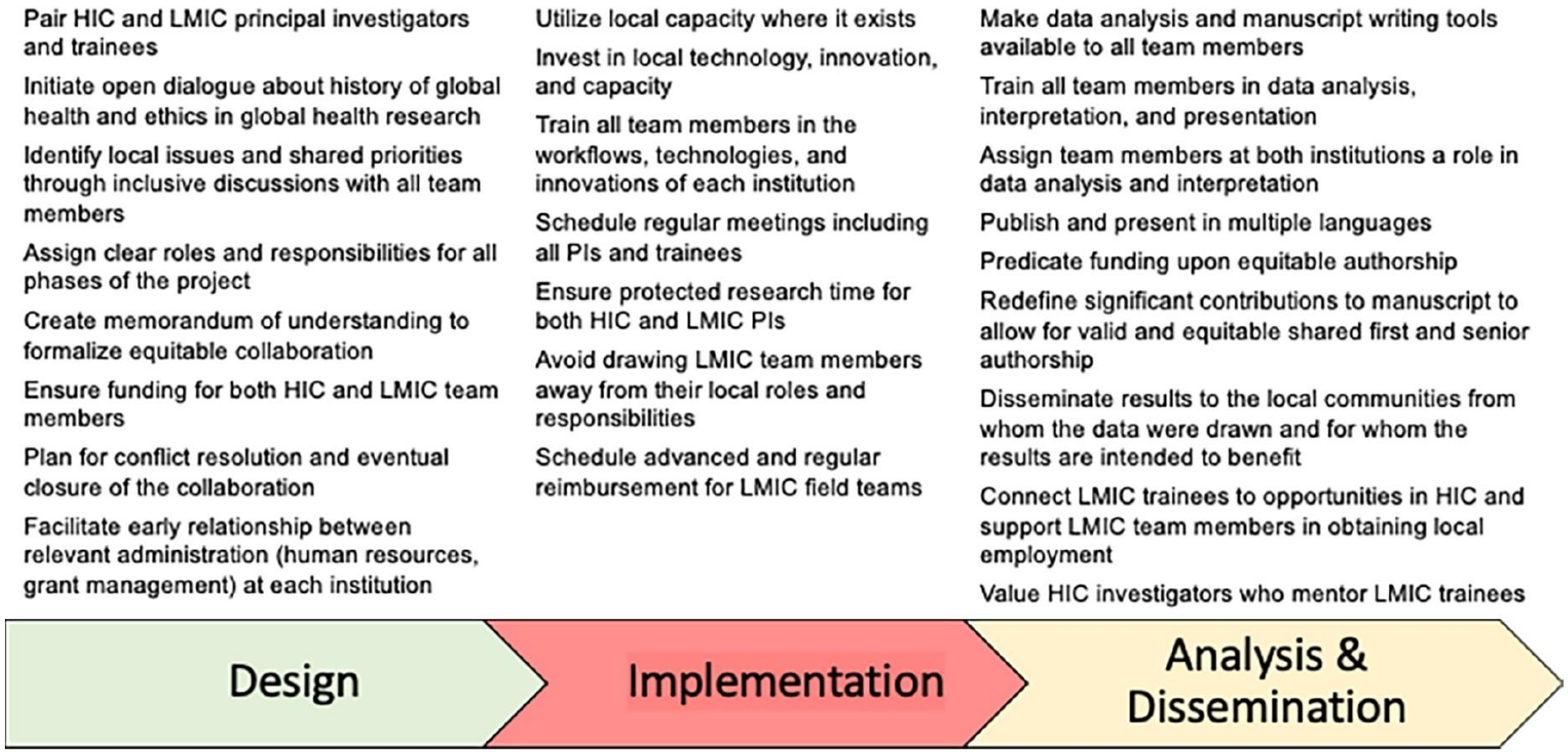


Fig 1. Recommendations for advancing equity in global health during each phase of research.

https://doi.org/10.1371/journal.pgph.0001418.g001

UCLA-UCT collaboration- what have we learned?

Ongoing collaboration to:

- Ensure funding, including conference attendance, for UCT team to attend & represent at conferences
  - Ex: Fully funded scholarships for our UCT team & New Investigator Award from our UCT Data Manager, Kalisha Bheemraj, for HIVR4P (Oct, 2024)!
  - Need to bring new PIs to get own funding at UCT (Dr. Alex deVoux, K43 application ongoing)
- Assign clear roles and responsibilities for all phases of the project
- Make data analysis & manuscript writing tools (and training) available to all team members
- Utilize local capacity in all roles of study including data management, analysis, dissemination

Kalisha Bheemraj, UCT Data Manager

In progress:

- Pair UCLA and UCT trainees to learn (& publish) together
  - Longer training opportunities (>3 months) are better for both for learning
  - Shorter are more likely to "parachute"
  - Co-write abstracts & publications (e.g., Nafisa Wara & Sumaya Dadan, WCE)

Nafisa Wara, UCLA GloCal Fellow with our UCT for 18 months

More effort needed:

- Redefine significant contributions to manuscripts to allow for equitable sharing of first and senior authorship
- LMIC funding opportunities remain limited- more HIC funding should be made available
- LMIC partners must identify and lead research opportunities and solutions
- Connect LMIC trainees to opportunities at UCLA to obtain training
  - Need additional funding & time to ensure UCT trainees and staff US-training

What can we do better to work <u>together</u> as allies?

"High income country institutions need to learn the lifelong practice of allyship, that is building relationships based on trust, consistency, and accountability with marginalized individuals and/or groups.

Hodson et al, PloS Global Public Health, 2023

To reach out:
Dvora Joseph Davey
dvoradavey@ucla.edu
dvora.josephdavey@uct.ac.za

References

Can Global Health abandon saviourism for justice?
https://healthjusticeinitiative.org.za/wp-content/uploads/2023/09/14.-Pandemic-Compendium_M.-Pai.pdf

Disrupting Global Health: From Allyship To Collective Liberation

https://www.forbes.com/sites/madhukarpai/2022/03/15/disrupting-global-health-from-allyship-to-collective-liberation/?sh=7688c0b24e62

Addressing power asymmetries in global health: Imperatives in the wake of the COVID-19 pandemic
https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003604

Will global health survive its decolonisation?
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32417-X/abstract

Towards authentic institutional allyship by global health funders
https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0003024

Rethinking Global Health: Frameworks of Power

https://www.taylorfrancis.com/books/oa-mono/10.4324/9781315623788/rethinking-global-health-rochelle-burgess

Justice in Global Health: New Perspectives and Current Issues
https://www.routledge.com/Justice-in-Global-Health-New-Perspectives-and-Current-Issues/Bhakuni-Miotto/p/book/9781032508450

Beyond Anthropocentrism: Health Rights and Ecological Justice
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8694298/pdf/hhr-23-007.pdf