FACULTY OF
HEALTH SCIENCES

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Re-imagining Global Health Training

World Congress Epidemiology

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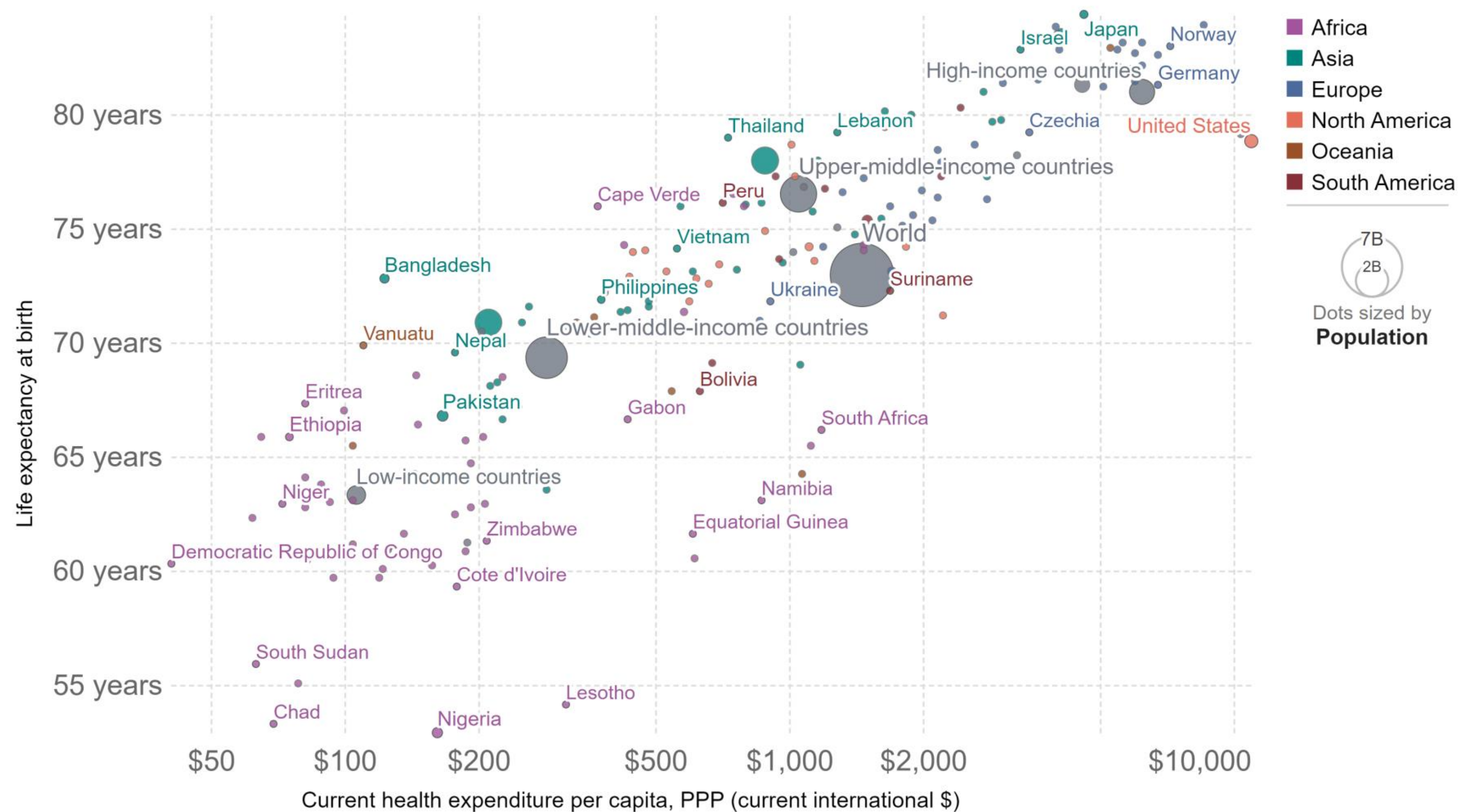
Cutting Edge Research
World Class Training and Education
Partnering for Patient-centred Health Services

110 YEARS Valuing Our Stories

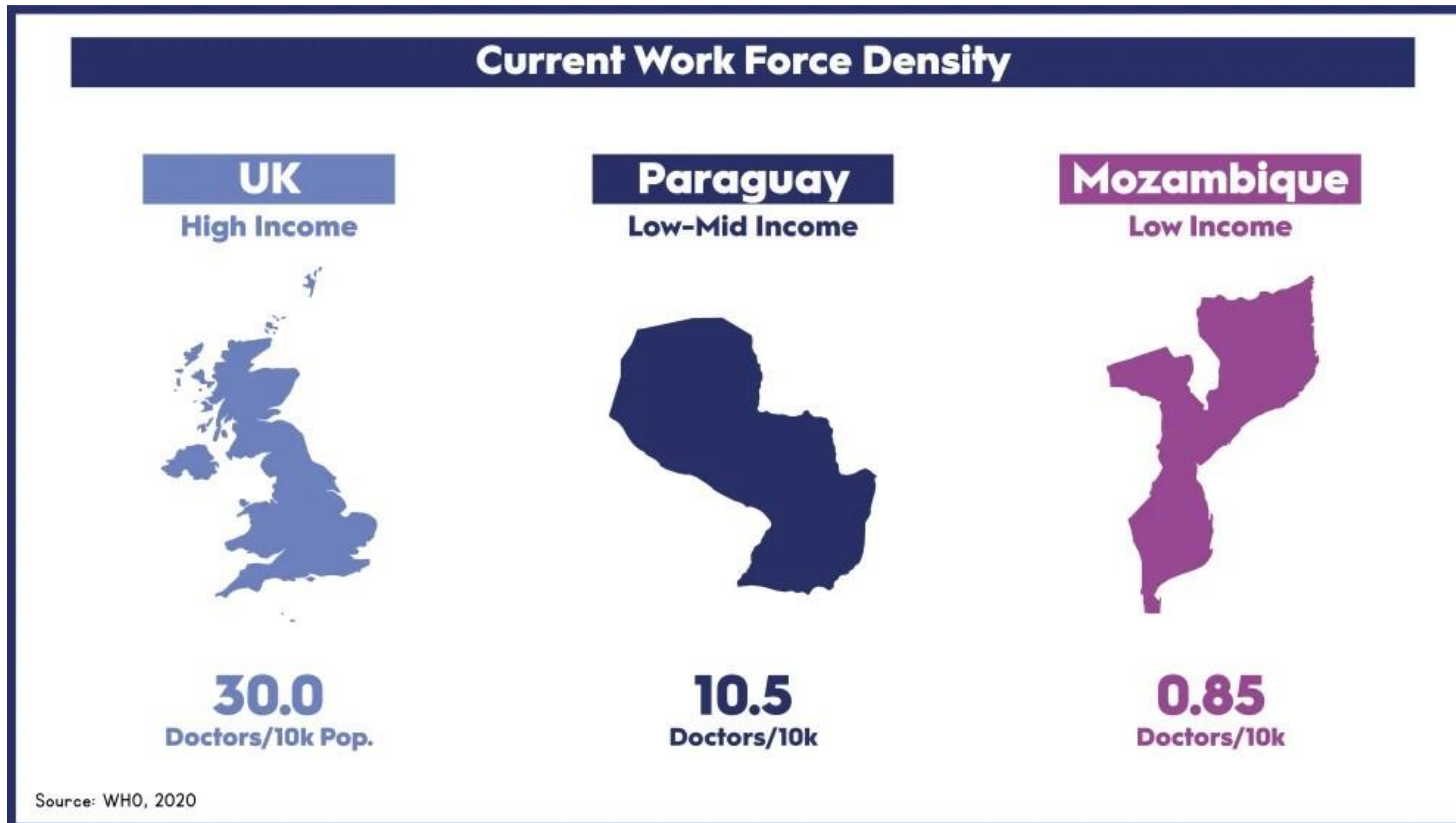
Global Health Training

- Education and capacity-building processes aimed at equipping healthcare professionals, researchers, and policymakers with the **knowledge, skills, and competencies needed to address health challenges that transcend national borders**.
- Aims to **improve health and achieving health equity** worldwide, particularly in low- and middle-income countries **(LMICs).**
- **Cross-Cultural Competency:** Prepares individuals to work effectively in diverse cultural, political, and economic contexts.
- **Problem-Solving in Resource-Limited Settings**: Emphasizes skills needed to design and implement health interventions in under-resourced environments.
- It often covers topics such as **infectious diseases, maternal and child health, health systems strengthening, global health policy, and emergency response**.

In the context of inequity and power imbalance


Life expectancy vs. healthcare expenditure, 2019
Healthcare expenditure per capita is measured in current international-$, which adjusts for price differences between countries.
Our World in Data
Life expectancy at birth
80 years
75 years
70 years
65 years
60 years
55 years
$50
$100
$200
$500
$1,000
$2,000
$10,000
Current health expenditure per capita, PPP (current international $)
Israel
Japan
Norway
High-income countries
Germany
Thailand
Lebanon
Czechia
United States
Upper-middle-income countries
Cape Verde
Peru
Vietnam
World
Bangladesh
Philippines
Ukraine
Suriname
Vanuatu
Nepal
Lower-middle-income countries
Eritrea
Bolivia
Pakistan
Gabon
Ethiopia
South Africa
Low-income countries
Niger
Namibia
Zimbabwe
Equatorial Guinea
Democratic Republic of Congo
Cote d'Ivoire
South Sudan
Lesotho
Chad
Nigeria
Africa
Asia
Europe
North America
Oceania
South America
7B
2B
Dots sized by
Population
Source: Data compiled from multiple sources by World Bank
OurWorldInData.org/financing-healthcare • CC BY

Global Inequity in HRH



Research in Africa

Africa 20% of earth's surface

1.3 billion people

30% of the world's reserve of minerals,

The youngest population of any continent

- 3% of global GDP, less than 3% international trade
- 25 percent of the global disease burden
- 2 % of World research output
- 1.3% research funding
- 0.1% patents

Editorial

BMJ Global Health

Global health is dead; long live global health! Critiques of the field and its future

Martha Lincoln

- Global health outcomes are conditioned by the dynamics **of international trade, foreign policy, and armed conflict**
- The political economy of global health implicates the **influence of austerity principles (manufactured scarcity) as the root cause of systemic dysfunction**
- Driven by neoliberalism **emphasising the use of market mechanisms** in favour of state entitlements
- The mechanisms for delivering medical services and resources to the Global South are **part of a global apparatus of political and economic domination** and not a hedge against it.
- **Blaming people for their behaviours** instead of attribution to a flawed system that drives these behaviours
- **External Agendas: Streetlight effect**—the tendency to search for something where the light is brightest
- Eradicate HIV/AIDS has driven large-scale shifts in priorities for resource expenditure

Global Health Curricula

- The majority of global health curricula and research **comes from HICs**
  - **Faculty HIC (power, decision making)**

- LMIC in Middle East: Global Health non-communicable diseases (29.2%), sexual and reproductive health (18.4%), and mental health (14.5%) with **important gaps in relation to the region's health needs.**

- Often fails to incorporate **social, economic, and political determinants** specific to LMICs.

- **Lack of Contextual Understanding**:
  - Language barrier
  - Programs frequently overlook local health systems, cultural norms, and indigenous knowledge.
  - E.g. Ebola failure to adequately consider local cultural practices, especially around death, burial, and mourning rituals. This oversight led to a significant spread of the virus and made containment efforts much more difficult.

- Direction of training towards LMIC **(student and faculty opportunities in HIC)**

- **Gender disparities:** underrepresentation of women researchers from LMICs more pronounced

Naal H, El Koussa M, El Hamouch M, Hneiny L, Saleh S. A systematic review of global health capacity building initiatives in low-to middle-income countries in the Middle East and North Africa region. Global Health. 2020 Jul 3;16(1):56. doi: 10.1186/s12992-020-00585-0. PMID: 32620141; PMCID: PMC7333284.

Kwete *et al. Global Health Research and Policy* (2022) 7:3
https://doi.org/10.1186/s41256-022-00237-3

Global Health
Research and Policy

REPORT Open Access

Decolonizing global health: what should be the target of this movement and where does it lead us?

Xiaoxiao Kwete[1*], Kun Tang[2], Lucy Chen[3], Ran Ren[4], Qi Chen[5], Zhenru Wu[6], Yi Cai[7] and Hao Li[7]

Colonial remnant in global health

Practices that further strengthen the unequal power hierarchy

Organization and regulations that put more power in the rich and the powerful

The unwritten norm that the developing world is incapable of solving its own health problems

Guiding Principle

- Peace
- Development
- Human rights
- Justice

World Order

- Multilateralism
- More power by Global South
- Shared prosperity

Decolonizing global health

Build global consensus to remove practices of colonial remnant

Move towards a multipolar global health governance structure centered with WHO

Push for a paradigm shift to believe that through continuous economic and social development, the developing world can solve its own health problems

Core components of equitable global health education and practice

From: The future of global health education: training for equity in global health

1. Engagement of **interdisciplinary teams** and an ability for all global health practitioners to **work respectfully and collaboratively**
2. Development of **equitable partnerships with shared leadership and stated, common goals**
3. **Alignment of priorities and research agendas that are driven by the low- or middle-income country partner**
4. Program management, problem-solving, and where possible, **financial oversight provided by the low- or middle-income partner**
5. Education of **trainees from the low- or middle-income country site is prioritized** over education of trainees from the high-income country partner
6. Applications for research or programmatic **funding opportunities are jointly conceived and written**
7. Research conducted jointly with **shared principal investigator and research team member roles**, publication authorship and presentations, and broad availability of findings through publication in open-access or HINARI-supported journals

Adams, L.V., Wagner, C.M., Nutt, C.T. et al. The future of global health education: training for equity in global health. BMC Med Educ 16, 296 (2016). https://doi.org/10.1186/s12909-016-0820-0

Conclusion

- To re-imagine global health training, we need to decolonise global health practice
- Breaking down structural determinants that drive health inequity
  - Manufactured scarcity is the root cause of systemic dysfunction
- Build Equitable, authentic respectful and reciprocal partnerships that equitably benefit students and faculty from HIC and LMIC
- Mindfulness and intentionality in managing power imbalances
- Advocate for investment in LMIC capacity development (gender), health systems strengthening

Thank You

Enkosi • Dankie

Kai Gangans

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