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Global health education in high-income countries: confronting coloniality and power asymmetry

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ABSTRACT

Contemporary global health education is overwhelmingly skewed towards high-income countries (HICs). HIC-based global health curricula largely ignore colonial origins of global health to the detriment of all stakeholders, including trainees and affected community members of low- and middle-income countries. Using the Consortium of Universities for Global Health's *Global Health Education Competencies Tool-Kit*, we analyse the current structure and content of global health curricula in HICs. We identify two major areas in global health education that demand attention: (1) the use of a competency-based education framework and (2) the shortcomings of curricular content. We propose actionable changes that challenge current power asymmetries in global health education.

> Imperialism leaves behind germs of rot which we must clinically detect and remove from our land but from our minds as well.
> —Frantz Fanon[1]

INTRODUCTION

At the core of contemporary global health lie power asymmetries between high-income countries (HICs) and nations that were once, or may still be, colonised. This has been identified by a number of studies and commentaries containing repeated calls for change. Chaudhuri *et al*[2] recently called for 'a complete overhaul of the colonial situation that is the global health industry'. The authors of this manuscript join their call, while narrowing their focus to the global health *education* industry.

Colonisation is fundamentally concerned with gaining territory and expanding power while extracting resources at the expense of indigenous populations. *Decolonisation* has become an academic buzzword, but at its core is a tangible revolutionary movement led by the colonised to reclaim power.[3] Its sister concept, *decoloniality*, is defined by Koum Besson *et al*'s[4] *Introduction to Decoloniality and Anti-Racism in Global Health: Student Toolkit* as 'a commitment to a praxis of undoing,

SUMMARY BOX

⇒ Global health as a field is plagued with power asymmetries that overwhelmingly favour high-income countries.
⇒ These asymmetries are replicated in global health education and the education's role in upholding these power asymmetries is underemphasised in previous calls for decoloniality in the field.
⇒ Two major areas in global health education emerge that demand attention: (1) the pervasive use of a competency-based education framework and (2) curricular content that lacks appropriate emphasis on colonialism in global health.
⇒ Actionable changes that promote decoloniality in global health education and challenge current power asymmetries are proposed, and these suggestions are meant as a starting point and are by no means exhaustive.
⇒ We close with a call to action that encourages all members of the discipline to engage with the question: what does a perfect global health programme look like?

unlearning, redoing, and relearning to create societies free from the remains of the colonial era in their culture, education and institutions'. Previous calls for change have underemphasised education's role in upholding colonial harms within the discipline, as well as its potential for positive change.

The Consortium of Universities for Global Health (CUGH) is an organisation that aims to provide support to worldwide academic institutions and partners in the field of global health and related disciplines. Unlike public health programmes, which have an accreditation process, global health curricula have no requisite standard.[5] In 2008, the CUGH identified this lack of standardised competencies across global health programmes. Redress was charged to CUGH's Competency Subcommittee, whose recommendations were published as the *Global Health Education Competencies Tool-Kit*.[6 7]

Table 1 Current issues and recommendations within HIC-based global health education

	Competency-based curricular model	Curricular content	
		Programme curriculum	Field experience
Current issues	▶ Reliance on competency-based curricular structure.	▶ Inadequate inclusion of racism and concepts of coloniality in the CUGH Tool-Kit. ▶ Anglocentrism within global health publishing narrows readily accessible scholarship from LMIC-based researchers.	▶ Short-term projects in LMICs perpetuate 'parachuting' practices.
Recommendations	▶ Adoption of acquired/participatory competency framework. ▶ Feedback prioritisation from LMIC stakeholders.	▶ Longitudinal curricular inclusion of the history and current manifestations of racism and coloniality. ▶ Intentional inclusion of work written by LMIC-based authors. ▶ Inclusion of interdisciplinary content (eg, anthropology, geopolitics). ▶ Exposure to LMIC cultures and experiences via alternative mediums (eg, novels, social media).	▶ Funding incentivisation for responsible project development. ▶ Collaborative acquired/participatory assessment development with LMIC host stakeholders. ▶ Equitable authorship credit for LMIC collaborators. ▶ Use of translation services to promote inclusive information sharing (eg, result dissemination, multilingual abstracts). ▶ Emphasis on local health as global health and de-emphasis on work in LMICs for 'global health' experience.

CUGH, Consortium of Universities for Global Health; HIC, high-income country; LMIC, low- and middle-income country.

The Tool-Kit defines competencies for global health higher education and professional development while providing teaching strategies and accompanying resources.[6] We argue that this resource can be used as a vehicle for assessing the current structure and content of global health curricula in HICs. As such, we analysed the Tool-Kit's suggested curricular content, its competency-based structure and the landscape of its contributors.

In this paper, we outline the current state of the global health education industry in HICs and offer specific recommendations (table 1) to challenge existing power asymmetries and hierarchies. We highlight (1) competency-based education and (2) gaps in curricular content as areas that demand prompt attention and offer the potential for harm reduction. We hope this analysis of current issues in global health education inspires faculty and students at HIC-based institutions to urgently implement necessary changes.

POWER ASYMMETRY IN CONTEMPORARY GLOBAL HEALTH

Contemporary global health leadership is overwhelmingly skewed towards HICs.[8] The Global Health 50/50 report examined 201 organisations involved in global health and policy. The majority (72%) were based in North America or Europe. Of 94 chief executive officers and board chairs appointed in 2020–2021, 76% were nationals of HICs and 88% were educated in HICs.[9] These power asymmetries are replicated at all levels of global health practice and are reinforced in the education system.

The early 2000s saw a rapid increase in the number of higher education-based global health programmes.[10] Svadzian et al[11] showed that 95% of Master's of Global Health programmes are located in HICs. Worldwide, these programmes are cost-prohibitive; programmes in HICs and low- and middle-income countries (LMICs) charge an average tuition of US$38 000, while those in the USA charge an average of US$68 000.[11] These blatant barriers to entry (eg, geographical location, visa hurdles and cost) work to homogenise the future make-up of global health professionals.

CUGH membership seems to reflect the current asymmetrical landscape of universities and institutions involved in global health education. Analysing the composition of the 183 worldwide member institutions of the CUGH, we found that 88.6% of the members are based in HICs and upper-middle-income countries (UMICs), while 11.4% are based in low-income countries (LICs) and LMICs (as categorised by the World Bank), as seen in figure 1.[12 13]

It is important to note that the CUGH originated in the USA, with foundational involvement from the USA and Canada.[14] We recognise that this predominantly North American perspective may limit our ability to use the Tool-Kit to assess global health curricula in HICs beyond the USA and Canada. However, we believe the Tool-Kit to be the most accessible standardised resource for global health curricular development and
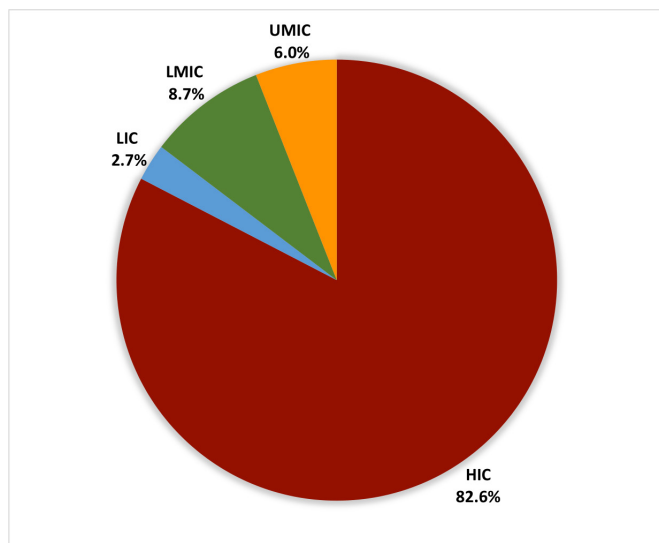
Figure 1 Consortium of Universities for Global Health Institutional Membership of Countries by Economical Stratification; HIC, high-income country; LIC, low-income country; LMIC, low- and middle-income country; UMIC, upper-middle-income country.

the closest available proxy for curricular priorities in HICs.

COMPETENCY-BASED CURRICULAR MODEL

Competency-based education in global health has drawn criticism. Competencies fall short in three major ways: (1) poor integration of knowledge and skills from LMIC professionals; (2) individualist approaches to learning which differ from collectivist approaches in LMICs; and (3) unsuitable metrics and insufficient resources for assessment.[15]

The CUGH Tool-Kit consists of a series of competencies and includes study questions that accompany its competencies. For example, Competency 5f of the Tool-Kit challenges trainees to 'Apply leadership practices that support collaborative practice and team effectiveness'.[6] However, the Tool-Kit's guidance on leadership fails to consider how the concept of leadership is defined differently across cultures. Additionally, without acknowledging HIC-dominated leadership, teaching HIC students to be good leaders is a dubious goal in and of itself.

Take for example an HIC student undergoing predeparture training prior to summer research in India. Student knowledge of the Indian sociopolitical and healthcare systems and their 'cultural competency' are assessed; on demonstrating competency, they are cleared to travel. This approach inappropriately assumes (1) all competencies can be acquired through individual, context-independent study; (2) competencies can be adequately measured and assessed by HIC-based approaches; and (3) metrics predict behaviour and outcomes in LMIC destinations.[15 16]

Critics of competency-based education proposed a novel approach whereby global health competencies are classified as *acquired* or *participatory*.[16] Acquired competencies are independent of context, for example, mastery of surgical techniques. Participatory competencies are heavily context-dependent and can be developed only through dynamic, in-situ learning.[16] In practice, adoption of an acquired/participatory competency framework is complex; concerns remain that any approach relying on competencies may reinforce the same colonial bent as other prescriptive approaches.[2] In response, acquired and participatory competencies should be developed collaboratively with actors in LMIC regions.

This shift to an acquired/participatory framework must extend to assessment of trainee development. For participatory competencies, this would ideally occur through self-directed assessment seeking, in which students proactively seek feedback, subsequently adjusting their behaviour.[16] Eichbaum[15] outlines a nuanced milestone approach to assessing trainee capacity, with topics including global self-awareness, perspective taking, and personal and social responsibility. Feedback should be prioritised from LMIC subjects of research or clinical care, as well as from faculty, peers and other stakeholders with whom the trainee interacts.

CURRICULAR CONTENT

As previously mentioned, the Tool-Kit should be viewed not as a definitive summary of global health training programmes, but perhaps as a reflection of shared expectations across institutions. Thus, it is worth unpacking the authors and content of the Tool-Kit. Of the listed contributing scholars in the Tool-Kit's first and second editions, only 2 of 38 (2017) and 3 of 32 (2018) are based at institutions outside the USA or Canada.[6] Non-US/Canada countries include Chile, Costa Rica and Nicaragua, but none in Africa or Asia. Furthermore, Nicaragua is the only represented LMIC among the Tool-Kit contributors.[13] This observation is no fault of the contributors themselves, but rather an illustration of the predominant voices behind global health curricular development in HICs, where ethical and intentional representation among contributors should be the goal.

When examining the content of the 229-page Tool-Kit, 'racism' is mentioned three times and themes of colonialism are presented four times.[6] These appear only in accompanying resources and not as main competencies, suggesting that the Tool-Kit does not highlight these subjects as fundamental to global health education, nor therefore would the programmes that use the Tool-Kit as a curricular guide.

Beyond the Tool-Kit, curriculum content suffers from the Anglocentrism that plagues the global health discipline at large.[17] Courses draw on and teach from current and ongoing research in the field, which is almost exclusively published in English and authored by HIC-based scholars. LMIC scholars face challenges, such as high article processing charges and translation barriers, when publishing in English-language journals. Further,

non-English language journals are unlikely to receive the same level of international exposure and impact.[18] This narrows the scope of the literature used to teach in HIC institutions and limits HIC engagement with LMIC advancements.[17] Journals should eliminate these barriers to publishing for LMIC-based scholars and educators ought to encourage scepticism of the exclusions inherent in academic publishing.

Curricula should include the history, current manifestations and consequences of racism and colonisation in global health, with longitudinal emphasis on decoloniality, antioppression, antiracism and allyship.[19] Course content should also focus on problems beyond 'health' and explore forces that affect health, like geopolitics, economics and civil infrastructure, as well as sanctions, violence and conflict. Activists and scholars of medical anthropology, economics, sociology, public health and urban planning are valuable collaborators and lecturers.

When selecting curricular resources, educators should make efforts to include popular media, art, novels, films and social media (eg, Twitter threads) that centre the culture and experience of LMIC populations. These unique resources must be appropriately cited and incorporated in such a way that showcases their value as educational tools. Additionally, curricula should prioritise scholarship of LMIC and under-represented scholars such as black, indigenous and people of colour on the forefront of decolonial work.[3]

Field experience

A core global health programme component is often 'field experience', during which students travel to work in an LMIC. Due to the discussed gaps in curriculum content, students often have variable understandings of colonisation and racism as they relate to global health and to the LMIC settings in which they train. Global health degree or certificate programmes often last 2–4 years; this time frame lends itself to single visits and short-term research projects and clinical practice. This practice has been dubbed 'parachuting' to connote HIC researchers that drop into LMICs for brief research projects and prioritise their scholarship over sustainable partnerships.[20] It also assumes that trainees from HICs are always beneficial to their LMIC hosts and underplay how they can drain local resources.[21 22]

To combat 'parachuting', projects should be carefully designed to optimise sustainability. HIC-based institutions should partner with scholars in LMICs on long-term projects. Trainees should be encouraged to conduct international research in regions where they have cultural ties and/or where they intend to maintain a relationship. Programmes and funding organisations can incentivise this when allocating funds for scholarship. HIC partners should provide the resources to ensure that hosting and teaching their trainees are not an undue burden.

'Parachuting' leaves little opportunity for feedback from LMIC collaborators and individuals who partook in research or received care. Consequently, harms that may have resulted from trainee involvement in LMICs are neither easily elucidated nor addressed. This presents an opportunity to use participatory competencies, as previously discussed, and to develop assessments of field experience collaboratively with host stakeholders. Competencies can be approximated prior to arrival and trainees can then seek feedback proactively in real time.

While research findings are disseminated formally through journals and conferences, they should also be shared with participants and partners in manners specific to regional norms. If pursuing publication of trainee work, programmes should promote equitable credit in terms of authorship (eg, if the HIC trainee is the first author, the LMIC supervisor could be the senior/corresponding author) and allocate funds for publication in open-access journals to optimise sustainable research collaboration. Additionally, in order to promote more inclusive information sharing, programmes can provide translation resources to generate multilingual abstracts of trainee publications.[17]

While LMIC-bound field experience has traditionally been a core component of HIC-based global health training programmes, some programmes have made concerted efforts to teach the connection between global and local health.[23] Programmes can encourage work in local communities, shifting focus to domestic challenges. We must de-emphasise the notion that work in LMICs is essential to global health education. Global health students must address inequities even within HIC settings.

CONCLUSION

In this article, we present areas of global health education where decolonial efforts can be made within HIC-based programmes, using the CUGH Tool-Kit as the closest available proxy for standardised curriculum guidelines in HICs. We would like to emphasise that our efforts are not intended to discredit the CUGH nor the organisation's Tool-Kit, but rather an attempt to bring attention to the current global health education landscape that suffers from a lack of decolonial content as well as a rigid competency-based structure. Notably, the contributors to the CUGH Tool-Kit state that the resource functions as a 'living document', 'starting point' and 'work in progress'.[6]

We believe the changes we have suggested in this article are essential and eminently feasible. As such, we must ask ourselves why they have not already been implemented. Ultimately, reconstruction of the field itself is limited by the willingness of leaders in HICs.[3] These leaders and institutions uphold the legacies of colonialism on which their institutions were built.[24] To this end, we are not certain that a truly just or equitable global health future can be brought about, but we believe in reducing harms wherever we can. These suggestions are one starting point to the necessary upending of the global health education industry.

While every educator and trainee must strive for an equitable global health future, many of the power asymmetries within the field are due to structures and forces outside individual control. We aim to highlight education's ability to expose insidious systems that maintain the current global health industry. We do not intend to create checklists for institutions that become watered-down accessories to global health education. Recommendations alone cannot absolve institutions or trainees of responsibility for harms perpetuated by past and present practice. Global health institutions and educators must become actively anticolonial—a transformation that would result in a loss of power for HIC actors.

We offer an opportunity to engage with the question: what does a perfect global health programme look like? Perhaps it has no borders or hierarchy or does not necessitate degree-seeking; perhaps focus shifts away from research and towards experiential learning. We urge students, academics and practitioners to imagine a new landscape and the tools needed for its actualisation.

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