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Commentary and Opinions

Broadening relevance and representation in global health medical education research: centring context, content, and voice

Accroître la pertinence et la représentativité de la recherche sur la formation médicale en santé mondiale : une affaire de contexte, de contenu et de point de vue

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Introduction

We read Pritchard et al's[1] paper on Global Health (GH) competencies in postgraduate medical education (PGME) with interest, and commend the authors on engaging with important areas in medical education and GH scholarship. The research team conducted a scoping review to find articles that discussed GH competencies in post graduate medical education (PGME) and then mapped the identified GH competencies to the CanMEDS competency framework. The scoping review identified 19 eligible articles which originated from only three countries (the USA, Canada, and the UK) despite not placing limits on language or country in their search. The subsequent exercise of mapping the competencies to the current CanMEDS framework showed significant overall alignment with the current CanMEDS competencies.

Pritchard et al. elegantly show that GH is a complex and contested space, with deeply entrenched power differentials between Global North and Global South participants in GH work. We appreciate the researchers' reflexive approach in the discussion and limitations section, where they comment that their study "re-illustrates the power differentials between the Global North and Global South existing in the field of Global Health."[1] Their results clearly point to the absence of voices, perspectives, and experiences from low-and middle-income countries (LMIC) in discussions about GH competencies. The research team also highlights the absence of more critical GH perspectives, particularly decolonial lenses, across the competencies examined in the 19 articles reviewed.

Pritchard et al's[1] work demonstrates the utility of examining completed research—in this case using scoping review methodology—to identify absences, assumptions, and limitations in particular content areas in medical education. Research that interrogates absences has been shown to be powerful in framing problems with the current state of the field.[2] While absence identification is critically important as a starting point, it does not necessarily provide a clear path forward. Through their thoughtful discussion about limitations, Pritchard et al.'s[1] work also shows how in analysing their results, researchers can learn from assumptions they made in framing their research questions. This is fundamental to good research practices. As the field of medical education advances, research teams may be able to draw upon findings of absence like Pritchard's to add nuance to ways they conceptualise and conduct future research projects.

To be transparent about our positionality, we authors are all deeply engaged in medical education globally, all work

in either medicine or public health, but none of us identifies as a GH or GH education expert. We write this commentary as a research team comprised of authors from one low-income country (LIC) and two high-income countries (HICs) who have grappled with issues of relevance and representation in previous and current research projects. In our shared work, we try to find ways to shift away from Global North, HIC-dominated perspectives in medical education. We are strongly committed to 1) scholarly capacity building for LMIC academics and 2) using scholarly findings to advocate for and enable the creation of more representative global academic spaces and conversations. We therefore provide some concrete suggestions for steps forward in terms of research practices, competency language, and GH education practices.

Our primary focus in this manuscript is on advancing inclusive GH scholarship in medical education using GH competencies as a relevant case to consider. Given that competencies are the dominant educational framework in the countries in which GH programs are most present, it is important to consider ways to make these competencies more robust and meaningful, while also remaining open to identifying aspects of medical education that may not be an ideal fit within competency models. One possible way to advance conversations as a community of medical education researchers could be to pose a series of questions related to **context, content, and voice** when conducting and reflecting upon research projects**.** These questions provide a starting point for discussion prior to embarking on projects that helps to move towards a shared understandings of what GH is, what education competently prepares medical learners for GH work, and what constitutes good GH research, education, and clinical practices. While this might be helpful across many areas of research in medical education, we suggest that it is even more of an imperative in research with a global reach, where it is essential to incorporate understandings of equity, diversity, and the continued legacies of colonialism in healthcare and medical education.

Context

One crucial public health competency that appears to be missing from the global health competencies identified by Pritchard et al. for PGME is the ability to recognize and account for context. Of the 36 Global Health competencies identified within PGME, none explicitly foregrounds the importance of context when engaging in medical or public health beyond one's own borders. The absence of any content about context across these current PGME GH competencies is disquieting and raises the question of whether these competencies can accurately be labelled as 'global' in their current form. Even the contested definitions of GH require consideration of what contexts 'count' as GH work. GH is sometimes understood as a space that primarily engages researchers, educators, and practitioners beyond their national borders; other times GH includes in-country work distinct from public health.[3] Emphasizing the contextual nature of global health work within PGME competencies may be one way of ensuring that global health research is responsive to the needs of local contexts.

Context is important because GH is currently predominantly a HIC endeavour. Throughout its history, it has been the purview of HIC scholars seeking to work and study beyond their own contexts, and GH has been described as "public health somewhere else" which raises questions about its very utility as a concept for LMIC public health practitioners and scholars.[4]

In 2020 more leaders of GH organizations were alumni of Harvard than were women from LMICs.[5] GH education, similarly, remains an area of study centred in HICs, with over 95% of Master of GH programs in 2022 being located in HICs with participants predominantly White, high income, Europeans and North Americans.[6] Reinforcing this, Pritchard et al's[1] study demonstrated that GH competencies in PGME have only been described in the literature by authors from the USA, Canada, and the UK. Acknowledging this, attention should be drawn to the historical development of the field of GH which remains steeped in its colonial legacies, having started as colonial medicine, morphing into missionary medicine, tropical medicine, and international medicine.[5,7-9]

If a global health context is one in which health systems are under-resourced and population health inequities are prevalent, then one might wonder what motivates so many HIC researchers to work beyond their national borders when there continue to be significant health inequities within their local contexts? Numerous rationales have been proposed for explaining HIC interest in global health, including altruistic motivations such as reciprocity and solidarity, as well as more self-interested motivations such as self-aggrandizement, sensationalism, and self-protection.[10,11] Alternatively, do GH scholars perceive an excess of regulation that makes it feel less possible to truly contribute to change within one's own contexts? In a discourse analysis of the social determinants of health

(SDOH) Raphael[12] acknowledges that despite the inclusion of the SDOH in Canadian policy documents, there has been a reluctance to identify and implement public policy that could help reduce national health inequities. It may simply be easier for HIC scholars to take their research questions and good deeds elsewhere.

Content

In a study of GH competencies, for example, we might ask questions about the current content of GH competencies (Table 1). Pritchard et al's[1] results showed that critical GH perspectives are entirely absent in published literature about GH competencies. They suggest that the GH competency literature is lagging other fields where critical perspectives are proliferating. Going forward, researchers might wish to ask how GH competencies can be refreshed in timely ways and if there are more inclusive methods researchers can use to avoid tokenism and to encourage meaningful LMIC participation. For education to be transformational, particularly in times of rapid educational change, it must be at the cutting edge of academic thinking, not stuck in the past.

Researchers may also consider what content is seen as fitting within the definition of GH. Currently, GH is an amorphous and ambiguous term, referring to initiatives with either a public health or a clinical health focus: any initiative undertaken outside of our local borders that has a health promoting component seems fair game for being labeled as GH. International medical electives often aim to include components of both clinical service and a community health orientation.[13] Further examining the GH competencies identified by Pritchard et al. may illuminate how GH is being defined and operationalized within PGME. In 2008, the Public Health Agency of Canada published core competencies for public health in Canada.[14] Many of Pritchard's identified core competencies also map onto the PHAC's competency framework: for example, Pritchard et al. identified a competency for "epidemiology, research and evaluation skills,"[1] which aligns with the public health competency of "demonstrating knowledge about the health status of populations."[14] The PHAC specifies that a public health practitioner should be able to "determine the meaning of information, considering the current ethical, political, scientific, socio-cultural and economic contexts."[14] The Consortium of Universities for Global Health (CUGH) have published a tool-kit for global health education competencies.[15] While these competencies are admittedly designed by HIC scholars for HIC programs, the importance of context is embedded within the competency domains of *social and environmental determinants of health, capacity strengthening, ethics, professional practice, health equity and social justice*, and *strategic analysis*.[16]

Table 1. Questions to assist in the exploration of context, content, and voice in global health research within medical education

	Questions
Context	What do we know about the contexts in which GH research is situated? What is the history of the GH concepts we are interested in? What are the current healthcare, education, social, economic, and political structures in which our GH research topic of interest is embedded? How do these contextual factors shape assumptions in GH that we need to pay attention to in designing our research projects? How might understandings of these current GH education structures be more explicitly incorporated into GH research projects in medical education to ensure that GH education is globally relevant?
Content	What do we know about the content area in which we are planning our GH medical education research projects? What assumptions are we making about this content? Are there particular values or areas of focus that we might wish to unpack before embarking on the project? Whose purpose is served by the knowledge generated from the research? Do mechanisms exist to ensure that relevant new knowledge is incorporated into GH competencies in a timely way?
Voice	Are those making decisions representative of the space in which the work takes place? If not, how might we create research teams that make sure to incorporate appropriately diverse voices and perspectives in project design and execution?

Voice

Paying attention to issues of voice and representation is of critical importance if we wish to engage in relevant and inclusive GH research in medical education. In designing a research project in GH education we need to think about who is making decisions and advancing scholarly work. The voices describing the research can have profound effects on how the story of the work is told that influence its relevance to various audiences including scholars, policymakers and practitioners.

In terms of GH competencies in medical education, we can ask questions about who is involved in the creation of these competencies. Pritchard et al[1] convincingly demonstrate that published scholarship on GH competencies in PGME is entirely HIC dominated with their finding that all 19 articles

published about GH competencies in PGME emanate from just three HIC countries. Is it ethically and morally acceptable, let alone appropriate GH education research, for such work to be exclusively that of HIC academics? Even if GH competencies are created by HIC faculty members to design the curriculum for HIC GH PGME electives, that does not make them de facto appropriate. Rather, we must carefully question whether these HIC-designed competencies are relevant and fit for purpose for HIC PGME trainees going into LMIC clinical settings.

There is potential tension between the priorities of the individual HIC learner on a GH elective and the priorities of patients and care providers in the LMIC settings in which the GH electives take place. Pritchard et al make clear the desirability of the electives for PGME trainees, suggesting that specialties benefit from offering these electives to attract residents to their programs. No matter how useful or desirable a GH elective might be for the HIC learner, unless there is clearly demonstrated added value for the LMIC faculty, learners, or patients in the elective's setting, GH electives may be problematic or harmful,[17,18] draining local resources or bringing HIC arrogance and colonial attitudes into LMIC clinical spaces. Without including and foregrounding the perspectives and voices of academics from the settings to which the HIC trainees go, GH electives may continue to serve the needs of learners in HICs rather than the needs of local LMIC communities.[19]

Moving forward

Bringing together issues of context, content, and voice can lead to creative ideas for next steps (Table 1). We propose that across the areas discussed above (GH research in medical education, the creation of GH educational approaches (CanMEDs competencies), and the need for frameworks for appropriate practices for out-of-country GH educational experiences), the establishment of a clearer definition of GH will be extremely important. Shared understandings of what contexts are GH contexts will need to be derived with the participation of academics, educators, and practitioners from many setting if they are to be globally relevant. In addition, while early conversations are beginning,[20,21] scholarship in GH and scholarship in medical education are currently somewhat separate spheres. Finding platforms and opportunities to promote dialogue between these two communities may allow scholars from both fields to bring together their perspectives to tackle these important tensions and challenges.

More specifically, to support inclusive GH research in medical education, scholars should seriously consider discouraging HIC-led or initiated research projects in LMICs. The first step for a HIC researchers should be to form meaningful relationships with colleagues working in the planned research setting. As a standard of good practice, this aligns with the "nothing about us without us" approach in Canada to research in Indigenous settings[22] and could lead to guidelines similar to the Tri Council Policy Statement Chapter 9 recommendations for research with First Nations, Inuit and Metis peoples in Canada.[23] In the spirit of building scholarly capacity globally, and as a practice to ensure that local expertise, experience, and knowledge are foregrounded, ideally HIC GH scholars would aim to take the lead from their LMIC academic colleagues and participate with humility in the co-creation of research projects.

An essential first step in creating more inclusive GH competencies is to be explicit about who these competencies are for. If, as is currently common, particularly within the Canadian context of CanMEDS, these competencies are designed primarily for HIC learners to go for out of country educational experiences, building understanding of the colonial history and ongoing legacies of inequities and power differentials into these competencies will be key. In terms of what voices would ideally be represented in decisions about content for GH competencies, while engagement of LMIC academics would obviously be ideal, it is problematic for HIC educators to expect these colleagues to contribute to HIC priorities over the needs in their local LMIC settings. Given that a goal of GH is more equitable care, medical education, and scholarship in all parts of the world, drawing upon LMIC resources for GH competency creation is only appropriate if the GH competencies being created are relevant for local learners in those settings. We propose that medical educators make sure to focus on the extent to which the GH competencies they develop are globally relevant for all medical learners. If they are not, Canadian medical educators will need to pay close attention to how to connect their CanMEDS competencies to broader global concerns. Particularly when considering the relevance of CanMEDS GH competencies in varied settings, this might include being alert to contexts in which GH competency-based frameworks may not be an ideal fit.

In terms of advancing good GH educational practices, we suggest that HIC academics should be working collaboratively with LMIC academic colleagues to examine

the effects of these GH electives in specific contexts. It is not acceptable for HICs to set an agenda for sending forth trainees eager for exotic educational experiences without deep engagement of colleagues from the settings into which the HIC learners go. Without the voices and perspectives of LMIC academics in GH research, education, and clinical care, HIC GH medical education scholars may find it hard to avoid perpetuating inequitable practices. To advance, we urgently need to create more spaces for respectful relationships and conversations between HIC and LMIC researchers, educators, and clinicians. Power hierarchies and historical inequities of course cannot be overcome through goodwill or respectful listening alone. However, the task of making global health medical education research more relevant and representative will require the shared attention of those currently dominant and those who have been under-represented. Through such conversations, both around broader historical and conceptual factors, as well as in the many small details that perpetuate current imbalances, we have the potential to nudge ourselves and our field forward.

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References

1. Pritchard J, Alavian S, Soogoor A, Bartels SA, Hall AK. Global health competencies in postgraduate medical education: A scoping review and mapping to the CanMEDS physician competency framework. *Can Med Educ J.* 2023;14(1):70-79. https://doi.org/10.36834/cmej.75275
2. Paton M, Kuper A, Paradis E, Feilchenfeld Z, Whitehead CR. Tackling the void: The importance of addressing absences in the field of health professions education research. *Adv Health Sci Educ Theory Pract*. 2021;26:5-18. https://doi.org/10.1007/s10459-020-09966-x
3. Chen X, Li H, Lucero-Prisno III DE, et al. What is global health? Key concepts and clarification of misperceptions: report of the 2019 GHRP editorial meeting. *Global Health Res Pol.* 2020;5:14. https://doi.org/10.1186/s41256-020-00142-7
4. King NB, Koski A. Defining global health as public health somewhere else. *BMJ Glob Health*. 2021;5:e002172. http://doi.org/10.1136/bmjgh-2019-002172
5. Abimbola S, Pai M. Will global health survive its decolonisation? *Lancet.* 2020;396:1627-1628. https://doi.org/10.1016/S0140-6736(20)32417-X
6. Gichane MW, Wallace DD. Dismantling and reimagining global health education. *Glob Health Action*. 2022;5(1):2131967. https://doi.org/10.1080/16549716.2022.2131967
7. Brazelton MA. Health for all?: Histories of international and global health. *Hist Compass*. 2022;20:e12700. https://doi.org/10.1111/hic3.12700
8. Keshri VR, Bhaumik S. The feudal structure of global health and its implications for decolonisation. *BMJ Glob Health.* 2022;7:e010603. http://doi.org/10.1136/bmjgh-2022-010603
9. Kwete X, Tang K, Chen L, et al. Decolonizing global health: What should be the target of this movement and where does it lead us? *Glob Health Res Pol.* 2022;7:3. https://doi.org/10.1186/s41256-022-00237-3
10. Philpott J. Training for a global state of mind. *Amer Med Assoc J Eth.* 2010;12(3):231-236. https://journalofethics.ama-assn.org/article/training-global-state-mind/2010-03
11. Taylor C E. Changing patterns in international health: Motivation and relationships. *Amer J Pub Health.* 2011;101(7):1213-1215.
12. Raphael D. A discourse analysis of the social déterminants of health. *Crit Public Health*. 2011;21(2):221-236. https://doi.org/10.1080/09581596.2010.485606
13. Cheng J, Hanson L. Production of the global health doctor: Discourses on international medical electives. *Engag Schol J.* 2018;4(1):161-80. https://doi.org/10.15402/esj.v4i1.315
14. Public Health Agency of Canada. *Core competencies for public health in Canada (Release 1.0).* Ottawa: Public Health Agency of Canada; 2008. Available at https://www.canada.ca/en/public-health/services/public-health-practice/skills-online/core-competencies-public-health-canada.html [Accessed Dec 8, 2022].
15. Consortium of Universities for Global Health (CUGH) Competency Sub-Committee. *CUGH global health education competencies tool-kit (2nd edition).* Washington, DC: CUGH Competency Sub-Committee.
16. Cherniak W, Latham E, Astle B, et al. Visiting trainees in global settings: Host and partner perspectives on desirable competencies. *Annals of Global Health*. 2017;83(2):359-368.
17. Bauer I. More harm than good? The questionable ethics of medical volunteering and international student placements. *Trop Dis Travel Med Vaccines*. 2017;3:5. https://doi.org/10.1186/s40794-017-0048-y
18. Prasad S, Alwan F, Evert J, Todd T, Lenhoff F. How the social contract can frame international electives. *AMA J Ethics*. 2019;21(9):e742-748. https://doi.org/10.1001/amajethics.2019.742
19. Khan R, Hodges B, Martimianakis MA, Cole D. Twelve tips for undertaking reflexive global health experiences in medicine. *Med Teach*. 2017;39(10):1023-1028. https://doi.org/10.1080/0142159X.2017.1333589
20. Naidu T. Says who? Northern ventriloquism, or epistemic disobedience in global health scholarship. *Lancet Glob Health.* 2021;9(9);e1332-e1335. https://doi.org/10.1016/S2214-109X(21)00198-4
21. Wondimagegn D, Whitehead C, Cartmill C, et al. Faster, higher, stronger – together? A bibliometric analysis of author distribution in top medical education journals. *BMJ Glob Health. 2023;8:e011656*. https://doi.org/10.1136/bmjgh-2022-011656
22. Indigenous Health Writing Group of the Royal College of Physicians and Surgeons of Canada. *Indigenous health primer.*

Ottawa ON: Royal College of Physicians and Surgeons of Canada. 2019.

23. Canadian Institutes of Health Research, Natural Sciences and *Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. Chapter 9: Research involving First Nations, Inuit, and Métis Peoples of Canada*. In: Tri-Council Policy Statement 2: Ethical Conduct for Research Involving Humans. 2022.