Decolonizing Global Health Education: Rethinking Institutional Partnerships and Approaches

Quentin G. Eichbaum, MD, PhD, MPH, MFA, MMHC, Lisa V. Adams, MD, Jessica Evert, MD, Ming-Jung Ho, MD, PhD, Innocent A. Semali, MD, MSc, PhD, and Susan C. van Schalkwyk, MPhil, PhD

Abstract

Global health often entails partnerships between institutions in low- and middle-income countries (LMICs) that were previously colonized and high-income countries (HICs) that were colonizers. Little attention has been paid to the legacy of former colonial relationships and the influence they have on global health initiatives. There have been recent calls for the decolonization of global health education and the reexamination of assumptions and practices underpinning global health partnerships.

Medicine's role in colonialism cannot be ignored and requires critical review. There is a growing awareness of how knowledge generated in HICs defines practices and informs thinking to the detriment of knowledge systems in LMICs. Additionally, research partnerships often benefit the better-resourced partner.

In this article, the authors offer a brief analysis of the intersections between colonialism, medicine, and global health education and explore the lingering impact of colonialist legacies on current global health programs and partnerships. They describe how "decolonized" perspectives have not gained sufficient traction and how inequitable power dynamics and neocolonialist assumptions continue to dominate. They discuss 5 approaches, and highlight resources, that challenge colonial paradigms in the global health arena. Furthermore, they argue for the inclusion of more transformative learning approaches to promote change in attitudes and practice. They call for critical reflection and concomitant action to shift colonial paradigms toward more equitable partnerships in global education.

In the United States and other high-income countries (HICs), the growth in the academic discipline of global health has occurred with little reflection on the discipline's historical legacies. Many students and faculty participating in global health endeavors are unaware that medicine's history in formerly colonized countries across the world is interwoven with colonialism and the subjugation of populations. For partnerships between institutions in the former colonizing countries (mostly HICs) and the formerly colonized countries (often low- and middle-income countries [LMICs]), these legacies have become elephants in the room during discussions and negotiations about global health initiatives, including those related to global health education.

Please see the end of this article for information about the authors.

Correspondence should be addressed to Quentin G. Eichbaum, Vanderbilt University Medical Center, 1301 Medical Center Drive, Nashville, TN 37232; email: quentin.eichbaum@vumc.org.

Acad Med. 2021;96:329–335.
First published online April 28, 2020
doi: 10.1097/ACM.0000000000003473

The term "global health" itself is fraught with assumptions and asymmetries. Colleagues in LMICs remind us that "global health"[1] is a convenient but artificial construct developed by HICs to describe health care routinely practiced in LMICs. The implication that the discipline of global health adopted by HICs represents a reframing of LMICs' reality should give us pause to question from whose perspective global health is being branded and pursued. In exploring this question, we must reexamine the role that colonialism continues to exert in tensions and assumptions in global partnerships. We must also consider what the growing awareness of colonialism's impact and the associated calls for "decolonization" mean for global health practice and education.[2]

"Decolonization" in this context reaches beyond removal of colonial power and dismantling of colonial structures to include decolonization of the mind[3] that made the colonizer feel superior and the colonized inferior by enforcing structural drivers of discrimination and barriers to self-determination. Higher education institutions have only recently started to grapple with the historical and political contexts of the global locations in which they work and to reassess how these contexts might affect global health curricula. Global health practitioners and researchers have begun to examine the legacies of colonialism and their lingering impact on the practice of global health as well as to challenge "neocolonialism," which perpetuates and reinforces the colonialist paradigm of control and influence through unrecognized actions, behaviors, attitudes, and beliefs.[4,5]

Bleakley and colleagues[6] argue that we need more scholarship to better understand and disentangle these complex legacies in global health education. They point out that "there is no body of literature discussing the relationship between post-colonial theory and medical education."[6] In this article, we seek to partly fill this gap. We present a brief analysis of the intersections between colonialism, medicine, global health, and academic research and education; we explore the lingering impact of colonialist legacies on current global health programs and partnerships in the academic context; and we highlight resources and approaches that challenge colonial paradigms and can be used by a variety of stakeholders. However, while considering these complex issues,

we remain aware of the implicit biases we may bring as a result of our own privilege and position. We recognize an irony in our seeking to push back against hegemonic thinking. Nevertheless, we come to this work in the hope of disrupting the status quo and moving the field forward.

Medicine's Role in Colonialism

Colonialism directly impacted medical practice and education in Africa by using medicine as a tool for domination and control. Medicine provided a biological rationale for assigning racial superiority or inferiority.[7] Thus, medicine was used to rationalize and justify inequities and excesses under imperial domination. Such rationalization is heard in the proclamation by French colonial strategist Herbert Lyautey that "[t]he only excuse for colonization is medicine…. [T]he physician, if he [sic] understands his role, is the most effective of our agents of penetration and pacification."[7]

This "penetration and pacification" manifested in various ways. "Tropical medicine," as it was called in colonial times, was used to control and restrict the movement of indigenous peoples, such as through quarantine measures of local populations designed to prevent the spread of human and livestock infections. Because colonized countries played an important role in sustaining colonial economies, colonizers were keen to prevent disruptions due to disease outbreaks. Medicine was critical for maintaining the health not only of colonial troops and administrators but also of the enslaved local workforce needed to build colonial infrastructure.[7]

Colonizers also promoted medical research for the purpose of understanding the diseases that ravaged and decimated colonial troops at higher rates compared with indigenous populations.[7] Understanding the biological correlates of these mortality differences was a path to retaining power over the colonies. Other research exploited effective local remedies such as quinine from the bark of the cinchona tree, which French chemists tried to purify. South Americans had known for centuries that quinine was an effective medicine for fighting fevers, and it became essential for treating malaria and other infectious fevers in African colonies, thereby helping colonial troops survive. Research on tropical diseases was also critical for understanding epidemics (e.g., cholera, which ravaged Europe) that were thought to derive from unhygienic slums in the colonies.[7]

The relationship between colonial powers and their subjugated colonies was one of unquestioned and "pathologic" power.[8] Colonial regimes ignored and often obliterated local cultures, religions, and education systems and attempted to substitute Western culture, education, and Christianity. Consequently, colonialism can be considered an important social determinant of health.[9] Writers and intellectuals from former colonies have drawn attention to the lingering pervasiveness of colonialist mindsets and attitudes. Among them, Ghanaian philosopher Kwasi Wiredu argues for "conceptual decolonisation"[10] and Kenyan author Ngũgĩ wa Thiong'o reminds Africans that "[a]longside the quest for political liberation from colonial powers, African intellectuals [should also call] for mental liberation or 'decolonising the mind.'"[3]

The impact of colonialism is still present in LMICs where students and trainees from HICs avidly seek to participate in "global health experiences."[11] In addition, recent work speaks to "disproportionate benefits for the HIC researchers"[12] in global health research despite many guidelines developed to foster good practices for collaboration. We need to understand how these vestiges of the colonialist mindset continue to infiltrate and influence global health partnerships so we can direct our efforts toward decolonizing these relationships and facilitating greater fidelity to promoting equity in global health education and practice.[8]

Power of Knowledge: Reinforcing the Colonialist Paradigm

Debates about decolonization are often premised on the assumption that "knowledge is power" and that the guardians of knowledge—the recognized "knowers," the knowledge community—are thus the powerful. The concepts of knowledge and knowers play out differently not only across disciplines and professions but also across geographical borders and cultures characterized by different knowledge systems. This power differential is, for instance, evident in responses to climate change where the former colonizers (HICs)—who built their economies with little attention to the environment that disproportionately impacted "colonized" LMICs—now dictate emission standards to these LMICs, just as their economies industrialize.[13]

De Sousa Santos argues that scientific knowledge "tend[s] to serve the social groups having more access to such knowledge."[14] Despite the recent focus on "knowledge transfer" in global health, this transfer has been largely unidirectional, flowing from HICs to LMICs. Scholarly outputs from HICs dominate the global knowledge space to the point of "epistemicide"[14,15] (i.e., "the killing of [other] knowledge systems"[15]). The balance of power often rests with HIC practitioners, researchers, and scholars to the detriment of LMIC knowledge systems.[15] The global bioethics discourse exemplifies this imbalance: Chattopadhyay et al describe how a lack of access to the published ethics literature makes it nearly impossible for bioethicists from LMICs to learn from, and contribute to, the global bioethics body of knowledge.[16] The consequence is an underrepresentation of LMIC ethics perspectives, diminishing the diversity of thought and ideas in the field.

Similarly, HICs tend to set the metrics for success in global health research to benefit themselves. Discussions of colonialist attitudes and practices in research have typically focused on the imbalance of research leadership, data ownership, and recognition, rather than questioning the HIC-dominant system used to describe, share, and disseminate findings and measure their impact. Mbaye et al[17] and Boum et al[18] report how aspects of research partnerships with LMICs in Africa are skewed to benefit the HIC partners. The donors frequently define the research priorities as well as how and where findings are published—often in journals unavailable in the LMIC host country, thereby limiting local impact.[17,18] Mbaye et al's review of articles on research in Africa showed that only 49.8% had an African first author and some failed to include any African authors.[17] Likewise, impact factors (a measure of article citation rates) benefit researchers from HICs because most high-impact journals are based in HICs and researchers prefer to cite and

publish in such journals. Global health research thus remains fraught with power dynamics and colonialist attitudes.

Conceptual Approaches to Decolonization

There is a growing literature reexamining the legacies of colonialism (and slavery) and their continued impact on current global health endeavors.[19] Efforts toward decolonization in global health are attempting to focus on developing meaningful, mutually beneficial partnerships. For example, a recent editorial in *The Lancet Global Health* calls for "closing the door on parachutes and parasites," referring to "parasitic researchers" who "parachute" in, use local infrastructure and talent, and then abscond with the data to publish as their own work.[20] Shifting entrenched positions and assumptions, however, requires more than simply setting guidelines and directives for collaboration across contexts. While these are necessary conditions for changing the current landscape, they are not sufficient. What is needed is an internal paradigm shift—a reversal of preconceived ideas, leading to new ways of engagement. Making this shift speaks to the notion of transformative learning. The basic tenets of transformative learning theory call for learning experiences that will challenge students' preconceived ideas, often by confronting them with "disorienting dilemmas."[21,22] To facilitate transformative learning, those involved in global health, both students and faculty,[23] need to critically reflect on "problematic frames of reference—sets of fixed assumptions and expectations" to foster both self-awareness and a deeper awareness of others.[22]

Critically reflecting on the predominant ways of thinking and being and shifting one's position are important for countering ingrained stereotypes and reflexive associations. A growing number of health professions education researchers are calling for incorporation of these concepts into health professions curricula. In a Lancet Commission publication, Frenk et al call for such curriculum renewal, identifying a need for "transformative learning" that includes "developing leadership attributes … to produce enlightened change agents."[23] It is these agents of change who are needed to address the concerns we raise in this article.

Leibowitz offers another response, from an educational perspective, arguing for a "cognitive justice" approach that recognizes the diversity of knowledges and, equally, the different ways of knowing.[24] This approach requires a global system that is prepared to evolve and change. It calls for a shared cultural humility,[25] which, in the context of global health education, would see future health care professionals become deeply aware of the assumptions they hold and the social drivers that reside in the communities in which they provide care.[26] Zembylas, similarly, calls for engagements that push educators beyond their comfort zones to a place of "pedagogic discomfort" in which they interrogate entrenched perspectives and attitudes (such as described above), explore areas of "mutual vulnerability" emerging from traumatic pasts, and bring partners together by applying the potential for compassion and "strategic empathy."[27]

To shift established practices in global health partnerships, these ideas must permeate curricula and influence the thinking of those responsible for curricular innovation. For example, global health curricula and predeparture training modules in HICs could include fundamentals of colonial theory and the sociohistorical impacts of colonialism in LMICs.

Facilitating a Paradigm Shift: 5 Approaches

Thus far, we have sought to respond to Bleakley et al's[6] call to bring the focus of the scholarly decolonization debate to current practices in global health education. Calls for decolonizing global health education should come with recommendations on how to facilitate such a paradigm shift. A number of efforts are aspiring to decolonize global health education in ways that are accountable, tangible, and meaningful. Here, we present 5 approaches to facilitating a shift toward a decolonized paradigm of global health education.

1. Decolonizing by emphasizing patient safety

Students and professionals from HICs frequently engage in direct patient care in LMICs during their global health experiences. While these short-term global health or medical service trips are well intended, they often operate with little accountability and with risks of sidelining or circumventing local health systems and potentially causing patient harm.[28] To address activities that may affect patient safety, the University of Minnesota has created Global Ambassadors for Patient Safety (GAPS), an open-access, modular online platform.[29] The GAPS tool serves several functions: It prepares students for ethical issues they may encounter abroad, emphasizes the risks to patient safety of inexpert or culturally and linguistically incongruent care provision, and mitigates moral distress by allowing students to decline to do things beyond their scope of training. It culminates in an oath, available in 7 languages, that students sign committing to be ambassadors for patient safety. This initiative is decolonizing in that it takes seriously—in terms of ethics, equity, and appropriate medical expertise—the safety of patients in LMICs.

2. Decolonizing by applying fair trade principles to educational programs

Fair Trade Learning is a movement led by GlobalSL, an organization focused on "partnership, mutual learning … transparency, and sustainability,"[30] to engage the global civil society in educational exchanges toward fostering a more just and equitable world. Its Fair Trade Learning rubric[31] is designed to tangibly and intentionally move (i.e., decolonize) global partnerships with power differentials along indicators of engagement, from an "entry" level toward an aspirational "ideal" of equity and balance of power and privilege (Chart 1). The indicators include common purpose, rights of the vulnerable, host community participation, recruitment, publications, and communication.

3. Decolonizing by developing global health curricula, learning objectives, and competencies

The Association of American Colleges and Universities (AAC&U) is dedicated to advancing "the public standing of liberal education by making quality and equity the foundations for excellence in undergraduate education in service to democracy."[32] The AAC&U offers 16 open-access VALUE (Valid Assessment of Learning in Undergraduate Education) rubrics intended for institutional-

Chart 1

Excerpt of the Fair Trade Learning (FTL) Rubric[a]

Indicator	Ideal	Advanced	Intermediate	Entry
Common Purposes	Agreement upon long-term mutuality of goals and aspirations	Agreement upon overlap of goals and aspirations	Clarity from multiple stakeholders regarding how service* supports community and participant interests	Existing connection facilitates immersive exchange; service is added to "make a difference"
Host Community Program Leadership	Community members have clear teaching, leadership roles; Community-driven research initiatives are co-owned, including fair authorship rights to any co-generated publications	Content and activities of program, from educational through development intervention, are owned by the community through diverse input by community members	Multiple community members have remunerated speaking and leading roles	Key dynamic community member facilitates access
Rights of the Most Vulnerable	Most vulnerable populations in community have been identified; appropriate training and safeguards are in place to ensure their rights and well-being in the community	Multiple community partners and stakeholders dialogue about and take action to ensure protection of most vulnerable populations that may be affected through the partnership	Vulnerable populations are not part of the exchange programming and/or specific steps are taken to ensure their rights and well-being specific to the exchange programming	Embedded assumption is that community partner leadership represents all members of the community
Theory of Change (community)	Reasons for partnership—in terms of community and student outcomes—are understood and embraced by multiple and diverse stakeholders	The partnership is infused with and guided by a clear understanding of its approach to community outcomes	Stakeholders discuss assumptions guiding community intervention, considering multiple models of service and development	Service is not tied to consideration of its implicit theory of student or community development, community partnership, or social change
Theory of Change (students)	Reasons for partnership—in terms of community and student outcomes—are understood and embraced by multiple and diverse stakeholders	Clear efforts are made to systematically grow targeted intercultural skills, empathy, and global civic understandings and commitments through best practices in experiential learning	Reflective practice is employed to advance student learning in relation to experiences	Service is not tied to consideration of its implicit theory of student or community development, community partnership, or social change

[a]The rubric fosters dialogue among stakeholders around essential dimensions of quality global partnerships. It offers a framing through which community, university, and/or nongovernmental organization partners may engage in dialogue in respect to Fair Trade Learning partnership principles. Excerpt Copyright © 2015 From Hartman E. Fair Trade Learning: A framework for ethical global partnerships. In: Larsen MA, ed. International Service Learning: Engaging Host Communities. New York, NY: Routledge; 2015. Reproduced by permission of Taylor and Francis Group, LLC, a division of Informa plc.

*Service is clearly a contested concept. Robert Sigmon's (1979) classic understanding of service-learning suggests those being served control the services provided; those being served become better able to serve and be served by their own actions; those who serve also are learners and have significant control over what is expected to be learned. This understanding informs the use of the term above, allowing space for communities and partner organizations to cocreate and identify how the various forms of service–including learning as service, direct physical service, project-based service, social advocacy, and many other forms–inform their partnership. [Sigmon R. Service-learning: Three principles. Synergist. 1979;8:9–11.]

level use to guide student educational development.[33] The rubrics were developed, using an iterative peer-review process, by teams of U.S. faculty experts who examined numerous university rubrics and documents for performance descriptors evaluating progressively sophisticated levels of learning attainment. Many of the VALUE rubrics are applicable to global health education, including those for inquiry and analysis, critical thinking, teamwork, intercultural knowledge and competence, and global learning.

Of note, here is the global learning rubric (Chart 2) designed to help guide student learning and development around diversity, equity, and local and global contexts. Through global learning, students are expected to

> (1) become informed, open-minded, and responsible people who are attentive to diversity across the spectrum of differences, (2) seek to understand how their actions affect both local and global communities, and (3) address the world's most pressing and enduring issues collaboratively and equitably.[34]

This rubric is relevant to decolonizing global health education in viewing the world as "a collection of interdependent yet inequitable systems."[34] Higher

Chart 2

Excerpt From the AAC&U Global Learning VALUE Rubric[a]

	Capstone 4	Milestone 3	Milestone 2	Benchmark 1
Global Self-Awareness	Effectively addresses significant issues in the natural and human world based on articulating one's identity in a global context.	Evaluates the global impact of one's own and others' specific local actions on the natural and human world.	Analyzes ways that human actions influence the natural and human world.	Identifies some connections between an individual's personal decision-making and certain local and global issues.
Perspective Taking	Evaluates and applies diverse perspectives to complex subjects within natural and human systems in the face of multiple and even conflicting positions (i.e. cultural, disciplinary, and ethical).	Synthesizes other perspectives (such as cultural, disciplinary, and ethical) when investigating subjects within natural and human systems.	Identifies and explains multiple perspectives (such as cultural, disciplinary, and ethical) when exploring subjects within natural and human systems.	Identifies multiple perspectives while maintaining a value preference for own positioning (such as cultural, disciplinary, and ethical).
Cultural Diversity	Adapts and applies a deep understanding of multiple worldviews, experiences, and power structures while initiating meaningful interaction with other cultures to address significant global problems.	Analyzes substantial connections between the worldviews, power structures, and experiences of multiple cultures historically or in contemporary contexts, incorporating respectful interactions with other cultures.	Explains and connects two or more cultures historically or in contemporary contexts with some acknowledgement of power structures, demonstrating respectful interaction with varied cultures and worldviews.	Describes the experiences of others historically or in contemporary contexts primarily through one cultural perspective, demonstrating some openness to varied cultures and worldviews.
Personal and Social Responsibility	Takes informed and responsible action to address ethical, social, and environmental challenges in global systems and evaluates the local and broader consequences of individual and collective interventions.	Analyzes the ethical, social, and environmental consequences of global systems and identifies a range of actions informed by one's sense of personal and civic responsibility.	Explains the ethical, social, and environmental consequences of local and national decisions on global systems.	Identifies basic ethical dimensions of some local or national decisions that have global impact.
Understanding Global Systems	Uses deep knowledge of the historic and contemporary role and differential effects of human organizations and actions on global systems to develop and advocate for informed, appropriate action to solve complex problems in the human and natural worlds.	Analyzes major elements of global systems, including their historic and contemporary interconnections and the differential effects of human organizations and actions, to pose elementary solutions to complex problems in the human and natural worlds.	Examines the historical and contemporary roles, interconnections, and differential effects of human organizations and actions on global systems within the human and the natural worlds.	Identifies the basic role of some global and local institutions, ideas, and processes in the human and natural worlds.

Abbreviations: AAC&U, Association of American Colleges and Universities; VALUE, Valid Assessment of Learning in Undergraduate Education.

[a]Global learning is a critical analysis of and an engagement with complex, interdependent global systems and legacies (such as natural, physical, social, cultural, economic, and political) and their implications for people's lives and the earth's sustainability. This excerpt is reprinted with permission from "*VALUE: Valid Assessment of Learning in Undergraduate Education*." Copyright 2019 by the Association of American Colleges and Universities. For the complete Global Learning VALUE Rubric, visit https://www.aacu.org/value/rubrics/global-learning.

education has a vital role in redressing such inequities by expanding knowledge and advancing global justice.

Similar efforts, such as the Consortium of Universities for Global Health (CUGH) Competencies Toolkit,[35] aim to define appropriate roles and competencies for trainees and professionals working toward health equity and understanding of other cultures and contexts. The CUGH competencies were devised with input from LMICs to guide HIC trainees and professionals in navigating complex situations in LMICs with humility and cultural sensitivity rather than reflexively defaulting to what may be HIC/colonialist approaches and attitudes.[35,36]

4. Decolonizing by addressing power dynamics and development narratives

The Asset-Based Community Development (ABCD) approach to community-based development intentionally counteracts "deficit-oriented mentalities that reinforce colonial power dynamics."[37] Such a mentality impels the HIC outsider to

be impelled by development narratives whose storylines focus on the deficits of resource-limited settings rather than their implicit strengths and assets. By such narratives, the outsider is presumed to be knowledgeable and capable compared with local communities, which are considered incapable and needy. ABCD aims to counteract this dynamic and ensure greater equity between the less resourced and more resourced (and powerful) stakeholders.

A similar initiative is Arnstein's Ladder of Citizen Participation,[38] which calls for organizations and partnerships to recognize and correct for disparate power dynamics through citizen control and delegated power. The concept of delegated power is salient to global health partnerships in education, research, or practice. It refers to the intentional yielding (decolonizing) of power by more resourced/powerful stakeholders to less resourced/less powerful counterparts. Citizen participation encourages integration of such power delegation into organizational structures for optimal effectiveness.[38]

5. Decolonizing by equalizing access and opportunity of educational experiences

In the past decade, many institutions have developed structured curricula for their global health exchanges. There is a growing recognition of the need for these exchanges to be reciprocal between countries, communities, and organizations, with coexploration of challenges and codevelopment of solutions. Progress has been slow as institutions struggle to contend with the complex legacies of colonialism and its entrenched policies and practices.

Where bidirectional exchanges exist, it is well known that HIC learners traveling to LMICs consistently outnumber LMIC learners traveling to HICs. One explanation for this imbalance is that HIC institutions assume their students are always "helping" in under-resourced settings. Yet, on the contrary, visiting HIC students often place a burden on already-stretched health care and medical education systems in LMICs. And when LMIC students visit HIC institutions, they frequently do not receive the level of attention that HIC students tend to receive from their LMIC hosts.

Some noteworthy model bidirectional exchange programs exist, and more are emerging. For example, the International Federation of Medical Student Associations has sustained a bidirectional exchange program since the 1950s. Through student-led organizations in 127 countries, over 15,000 exchanges take place annually, using a structure where each outgoing student pays in their local currency for the cost of an incoming student and that student's cost of living.[39]

Moving beyond reflection to action

Using the above approaches could help stakeholders critically assess practices in global health education and practice and move toward more equitable dynamics that foster the transformative learning and cognitive justice described earlier. While it is essential to begin by examining how (neo)colonialist assumptions and attitudes permeate our global health programs, we must move beyond reflection and take action to decolonize our policies and practices. Application of these approaches could begin the dialogue and encourage shifts in how we conceptualize and enact partnerships. Candid discussions with LMIC partners about efforts undertaken to foster greater equity may promote a more thoughtful and inclusive process. We suggest incorporating the resources described above into predeparture trainings and faculty development seminars. These resources have been used by a variety of national and international organizations and institutions to bring intentional challenges to predominantly colonialized practices.[37,40–43]

Conclusion

If global health is to be based on principles of equity,[8] we must confront the historical legacies of colonialism that continue to perpetuate imbalanced power dynamics and inform attitudes and perspectives in our global health partnerships and educational programs. We need to address our collective ignorance of these legacies and their impacts on our behaviors and educational practices. The continuing growth in global health education necessitates fresh evaluation of these power dynamics.

In this article, we have presented approaches and resources to challenge colonial paradigms and facilitate the shift toward a "decolonized" state that would include equitable partnerships in global health education. Creating opportunities for transformative learning in our curricula could promote changes in attitudes among future health care professionals, ultimately leading to meaningful structural changes in our policies and programs. We must go beyond standards and guidelines to use practical tools, development approaches, and program structures to pursue decolonialized partnerships.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

Q.G. Eichbaum is professor of pathology, microbiology and immunology, and director, Vanderbilt Pathology Program in Global Health, Vanderbilt University Medical Center, as well as professor of medical education and administration, Vanderbilt University School of Medicine, Nashville, Tennessee.

L.V. Adams is associate dean for global health, associate professor of medicine and epidemiology, and director, Center for Global Health Equity, Geisel School of Medicine at Dartmouth and Dartmouth College, Hanover, New Hampshire; ORCID: http://orcid.org/0000-0002-1303-2154.

J. Evert is assistant clinical professor, Department of Family and Community Medicine, University of California, San Francisco, San Francisco, California, and executive director, Child Family Health International, Oakland, California; ORCID: http://orcid.org/0000-0002-3669-7693.

M.-J. Ho is professor, Department of Family Medicine, Georgetown University School of Medicine, associate director, Center for Innovation and Leadership in Education, Georgetown University Medical Center, and director of education research, MedStar Health, Washington, DC.

I.A. Semali is senior lecturer, Epidemiology, Hubert Kairuki Memorial University, Dar es Salaam, Tanzania.

S.C. van Schalkwyk is professor, Health Professions Education, and director, Centre for Health Professions Education, Faculty of Medicine and Health Sciences, Stellenbosch University, Stellenbosch, South Africa; ORCID: http://orcid.org/0000-0003-1596-6791.

References

1 Koplan JP, Bond TC, Merson MH, et al; Consortium of Universities for Global Health Executive Board. Towards a common definition of global health. Lancet. 2009;373:1993–1995.
2 Guinto R. #DecolonizeGlobalHealth: Rewriting the narrative of global health. International Health Policies. https://www.internationalhealthpolicies.org/blogs/decolonizeglobalhealth-rewriting-the-narrative-of-global-health. Published February 2019. Accessed March 25, 2020.

3 Wa Thiong'o N. Decolonising the Mind: The Politics of Language in African Literature. Nairobi, Kenya: East African Publishers; 1994.
4 Khan R, Hodges B, Martimianakis MAT, Cole D. Twelve tips for undertaking reflexive global health experiences in medicine. Med Teach. 2017;39:1023–1028.
5 Whitehead C, Wondimagegn D, Baheretibeb Y, Hodges B. The international partner as invited guest: Beyond colonial and import–export models of medical education. Acad Med. 2018;93:1760–1763.
6 Bleakley A, Brice J, Bligh J. Thinking the post-colonial in medical education. Med Educ. 2008;42:266–270.
7 Greene J, Basilico M, Kim H, Farmer P. Colonial medicine and its legacies. In: Farmer P, Kim JY, Kleinman A, Basilico M, eds. Reimagining Global Health: An Introduction. Berkeley, CA: University of California Press; 2013.
8 Farmer P. Pathologies of power: Health, human rights, and the new war on the poor. N Am Dialog. 2003;6:1–4.
9 Czyzewski K. Colonialism as a broader social determinant of health. Int Indigenous Policy J. 2011;2:5.
10 Wiredu K. Cultural Universals and Particulars: An African Perspective. Bloomington, IN: Indiana University Press; 1996.
11 McKinley DW, Williams SR, Norcini JJ, Anderson MB. International exchange programs and U.S. medical schools. Acad Med. 2008;83(10 suppl):S53–S57.
12 Hedt-Gauthier B, Airhihenbuwa CO, Bawah AA, et al. Academic promotion policies and equity in global health collaborations. Lancet. 2018;392:1607–1609.
13 Watts N, Adger WN, Ayeb-Karlsson S, et al. The Lancet Countdown: Tracking progress on health and climate change. Lancet. 2017;389:1151–1164.
14 de Sousa Santos B. Epistemologies of the South: Justice Against Epistemicide. New York, NY: Routledge; 2014.
15 Hall BL, Tandon R. Decolonization of knowledge, epistemicide, participatory research and higher education. Res All. 2017;1:6–19.
16 Chattopadhyay S, Myser C, Moxham T, De Vries R. A question of social justice: How policies of profit negate engagement of developing world bioethicists and undermine global bioethics. Am J Bioeth. 2017;17:3–14.
17 Mbaye R, Gebeyehu R, Hossmann S, et al. Who is telling the story? A systematic review of authorship for infectious disease research conducted in Africa, 1980-2016. BMJ Glob Health. 2019;4:e001855.
18 Boum Ii Y, Burns BF, Siedner M, Mburu Y, Bukusi E, Haberer JE. Advancing equitable global health research partnerships in Africa. BMJ Glob Health. 2018;3:e000868.
19 McGibbon E, Mulaudzi FM, Didham P, Barton S, Sochan A. Toward decolonizing nursing: The colonization of nursing and strategies for increasing the counter-narrative. Nurs Inq. 2014;21:179–191.
20 Closing the door on parachutes and parasites [editorial]. Lancet Glob Health. 2018;6:593.
21 Mezirow J. On critical reflection. Adult Educ Q. 1998;48:185–198.
22 Mezirow J. Transformative learning as discourse. J Transform Educ. 2003;1:58–63.
23 Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. Lancet. 2010;376:1923–1958.
24 Leibowitz B. Power, knowledge, and learning: A humble contribution to the decolonisation debate. Presented at: 10th Annual Teaching & Learning Conference, University of KwaZulu-Natal, Durban, South Africa; August 2016.
25 Tervalon M, Murray-García J. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9:117–125.
26 Ng SL, Kinsella EA, Friesen F, Hodges B. Reclaiming a theoretical orientation to reflection in medical education research: A critical narrative review. Med Educ. 2015;49:461–475.
27 Zembylas M. Critical pedagogy and emotion: Working through "troubled knowledge" in posttraumatic contexts. Crit Stud Educ. 2013;54:176–189.
28 Crump JA, Sugarman J; Working Group on Ethics Guidelines for Global Health Training (WEIGHT). Ethics and best practice guidelines for training experiences in global health. Am J Trop Med Hyg. 2010;83:1178–1182.
29 University of Minnesota. Global ambassadors for patient safety. https://www.healthcareers.umn.edu/courses-and-events/online-workshops/global-ambassadors-patient-safety. Accessed April 23, 2020.
30 Hartman E. A strategy for community-driven service-learning and community engagement: Fair Trade Learning. Mich J Commun Service Learn. 2015;22:97–100.
31 Hartman E. Fair Trade Learning: A framework for ethical global partnerships. In: Larsen MA, ed. International Service Learning: Engaging Host Communities. New York, NY: Routledge; 2015:226–229.
32 Association of American Colleges and Universities. Mission statement. https://www.aacu.org/about/mission. Updated November 2017. Accessed April 14, 2020.
33 Association of American Colleges and Universities. VALUE rubric development project. https://www.aacu.org/value/rubrics/global%E2%80%90learning. Accessed April 14, 2020.
34 Rhodes T. Assessing Outcomes and Improving Achievement: Tips and Tools for Using Rubrics. Washington, DC: Association of American Colleges and Universities; 2010.
35 Jogerst K, Callender B, Adams V, et al. Identifying interprofessional global health competencies for 21st-century health professionals. Ann Glob Health. 2015;81:239–247.
36 Cherniak W, Latham E, Astle B, et al. Visiting trainees in global settings: Host and partner perspectives on desirable competencies. Ann Glob Health. 2017;83:359–368.
37 Evert J. Teaching corner: Child family health international: The ethics of asset-based global health education programs. J Bioeth Inq. 2015;12:63–67.
38 Arnstein SR. A ladder of citizen participation. J Am Instit Planners. 1969;35:216–224.
39 International Federation of Medical Students' Associations. Professional exchanges. https://ifmsa.org/professional-exchanges. Accessed April 14, 2020.
40 McConnell KD, Horan EM, Zimmerman B, Rhodes TL. We Have a Rubric for That: The VALUE Approach to Assessment. Washington, DC: Association of American Colleges and Universities; 2019.
41 Hartman E, Paris CM, Blache-Cohen B. Fair Trade Learning: Ethical standards for community-engaged international volunteer tourism. Tour Hosp Res. 2014;14:108–116.
42 Hartman E, Chaire C. Market incentives and international volunteers: The development and evaluation of fair trade learning. J Public Scholarship Higher Ed. 2014;4:31–68.
43 Hartman E, Paris CM, Blache-Cohen B. Tourism and transparency—Navigating ethical risks in volunteerism with fair trade learning. Insight Afr. 2012;42:157–168.