Global Health Education in the Time of COVID-19: An Opportunity to Restructure Relationships and Address Supremacy

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Abstract

Global health and its predecessors, tropical medicine and international health, have historically been driven by the agendas of institutions in high-income countries (HICs), with power dynamics that have disadvantaged partner institutions in low- and middle-income countries (LMICs). Since the 2000s, however, the academic global health community has been moving toward a focus on health equity and reexamining the dynamics of global health education (GHE) partnerships.

Whereas GHE partnerships have largely focused on providing opportunities for learners from HIC institutions, LMIC institutions are now seeking more equitable experiences for their trainees. Additionally, lessons from the COVID-19 pandemic underscore already important lessons about the value of bidirectional educational exchange, as regions gain new insights from one another regarding strategies to impact health outcomes. Interruptions in experiential GHE programs due to

COVID-19-related travel restrictions provide an opportunity to reflect on existing GHE systems, to consider the opportunities and dynamics of these partnerships, and to redesign these systems for the equitable benefit of the various partners. In this commentary, the authors offer recommendations for beginning this process of change, with an emphasis on restructuring GHE relationships and addressing supremacist attitudes at both the systemic and individual levels.

Global health and its predecessors, tropical medicine and international health, have historically been driven by the agendas of institutions in high-income countries (HICs), with power dynamics that have disadvantaged partner institutions in low- and middle-income countries (LMICs).[1] Since the 2000s, however, the international academic global health community has embraced definitions of *global health* that focus on working to achieve health equity through collaborative and multidisciplinary practice that incorporates both individual- and population-level actions and concentrates on health concerns and determinants that are not bound to a single geography or culture.[1–3] This shift has coincided with growing critiques of the power structures, built by past colonization of partner countries, that have influenced global health practice.

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Global health education (GHE) programs engage learners to develop an understanding of health and related issues in communities that are typically different from their own. There is great demand for both classroom-based and experiential learning opportunities which emphasize cultivating the outsider's perspective. Many institutions provide opportunities for learners to immerse themselves in unfamiliar medical and social cultures, so as to gain insights into disease and pathology as well as the impacts of power, privilege, and socioeconomic inequality on the health of individuals and communities. However, much of this has centered on HIC institutions seeking GHE opportunities in LMIC settings or ways to provide volunteer service opportunities in less privileged health care settings. Over time, LMIC institutions have become more empowered partners, as faculty travel and improved access to scientific literature have provided increased exposure to information about HIC health care system resources. LMIC institutions now seek more equitable GHE relationships and opportunities for their trainees. The increasing calls to decolonize the field of global health point to the historical impact of these relational imbalances on LMIC institutions.[4–6] Thus, if GHE is to evolve as a field that meets the needs

of both HIC and LMIC institutions (and, ultimately, the needs of patients around the world), the existing power structures must be critically examined and redesigned with a focus on achieving equitable institutional relationships and promoting leaders who more accurately represent the gender, professional, and geographic balance of the global health workforce.

As we write this commentary in December 2020, COVID-19-related travel restrictions have paused many GHE programs and prompted others to embrace different goals and pedagogies. We believe this disruption offers a valuable opportunity to drive GHE in a new direction by allowing institutions to reflect on their priorities and the power dynamics of existing GHE systems and to work to redesign these systems for the equitable benefit of all partners. We recommend beginning this process of change with an emphasis on restructuring GHE relationships and addressing supremacist attitudes at both the systemic and individual levels.

Restructuring Relationships

The COVID-19 pandemic has driven many GHE programs to enact changes to their learning activities and,

consequently, some are reexamining their educational relationships with partner institutions at home and in other countries. This process should start with a focus on communication—both to ensure a stable platform for communication (sometimes in the face of disparities in internet connectivity for programs that have shifted to increased virtual engagement with partners) and to address key stakeholders' roles and responsibilities as well as issues related to systems, language, and/or cultural differences. Establishing this foundation should then lead to open conversation about the needs of each partner and their contributions to the relationship. This is the first step in establishing mutually beneficial goals and shifting the relationship toward one in which each partner is satisfied with the degree to which its needs are being met.

Our perspective on GHE partnerships is driven in part by our experience with the Makerere University/Yale University collaboration, a bidirectional GHE capacity-building program which 2 of us co-direct (H.M.-K. and T.L.R.).[7] This program, which is in its 15th year and has expanded to incorporate participants from other U.S. institutions, is structured according to a framework of 4 global health ethics principles (introspection, humility, solidarity, and social justice)[8] that are useful in guiding conversations about partnership equity. Examples of other HIC–LMIC academic partnerships that have similar goals with respect to building equitable relationships include the Academic Model Providing Access to Healthcare[9] and the Toronto Addis Ababa Academic Collaboration.[10] For those who seek additional guidance, Adams et al[11] provide a set of core components for equitable HIC–LMIC GHE and practice partnerships, including the presence of: interdisciplinary teams that work together in a respectful and open collaborative manner; shared leadership; explicit, shared goals; the LMIC partner as the driver of partnership priorities, the research agenda, and program management; and prioritization of the education of LMIC trainees over HIC trainees.

Extrapolating from these models, it is important to ask 3 questions of all GHE institutional partners, both those in one's home community or region and those in other countries: "What does your institution expect to gain from interaction with my institution?" "How is a relationship with my institution going to benefit yours?" and "What are the potential added burdens on either side that need to be addressed?" Focusing on the quality of relationships may lead to the demise of some partnerships that are not able to achieve a mutually beneficial arrangement, but this may also pave the way for changes to systems for implementing GHE activities or the establishment of new partnerships. Through conversations with local institutions, both HIC and LMIC institutions may find potential partners within their own country or region that meet their needs and educational objectives just as well as, or even better than, more distant partners.

Additionally, academic institutions are using online tools in creative ways to continue providing medical education during the COVID-19 pandemic, including developing opportunities to conduct shared GHE experiences (e.g., led by faculty from one institution or run jointly by faculty from multiple institutions). This can allow more trainees to be exposed to the experiences and expertise of partner institution faculty, as well as to a wider breadth of perspectives through paired or team-based learning with students from other sites. As has been noted, the presence of diverse perspectives is a key characteristic of successful teams and may inspire further innovations in education or practice.[12]

Lastly, as the GHE community focuses more on building up learning experiences at home during the pandemic, opportunities exist to partner more closely with colleagues working domestically and intrainstitutionally in the areas of health disparities and social determinants of health. Leveraging these relationships to highlight and delve into the power and privilege dynamics that affect health equity in one's home community may have an even greater impact than experiences abroad as these local lessons directly relate to learners' future practice.

Addressing Supremacy

The colonial (and do-good) roots of global health and related fields, along with the resultant web of entrenched power structures that maintain the status quo, have been well described.[4–6] The central issues relate to the possession and flow of money and control of global research and training agendas, which have largely rested in the hands of HIC institutions. These structural inequities, coupled with socially ingrained attitudes that equate power with knowledge, reinforce the perception that individuals from HIC institutions are best positioned to play the role of teacher. Thus, as learners travel to other communities and countries for the purpose of experiential education, the influence of global power structures that have historically favored wealthy institutions may manifest among the visitors as counterproductive supremacist attitudes. Abimbola and Pai describe these attitudes as taking the form of "persisting disregard for local and Indigenous knowledge, pretence of knowledge, refusal to learn from places and people too often deemed 'inferior,' and failure to see that there are many ways of being and doing."[5]

Changes related to the COVID-19 pandemic can impact these power dynamics in 3 ways. First, as we note above, the pause in immersive, travel-based experiences creates an opportunity for evaluation and open conversations between partners. These should include discussion of the degree to which supremacist attitudes have previously impacted the experience for both hosting and sending institutions. This pause also allows institutions time to implement recommendations for revamping or developing curricula and predeparture training that incorporate the colonial history of global health and teach the concept of cultural humility as a strategy for navigating future experiences.[6]

Second, despite the marked differences in the financial resources of HIC and LMIC institutions that affect the implementation of GHE experiences, it is imperative that all partners consider innovative approaches and different, largely virtual educational modalities in the context of the pandemic and for the future. Given the importance of global engagement, the goal should be to foster meaningful learner experiences, within the limits of each partner's financial/socioeconomic ability and bolstered by the resources of global partners.

Third, as some GHE programs turn to learning experiences in their home communities, opportunities exist to focus attention on the dynamics of power and privilege that affect individuals locally. Bringing a GHE focus to clinical training opportunities at home provides an important gateway for conversations about systemic racism in medicine and society and its many impacts on health, both direct and indirect (i.e., upstream disparities in socioeconomic determinants).

Supremacist attitudes could also be addressed through development of a GHE framework that elevates the experience of all stakeholders and redistributes power by redefining who is qualified to serve as a leader or teacher, based on individual country and/or institution leadership and academic standing, not simply on the HIC institution's needs and expectations. As we mentioned above, recent definitions of *global health* advocate collaborative and multidisciplinary approaches and attention to a broad spectrum of health determinants.[1–3] And there is increasing recognition of the value of bidirectional educational exchange, as different regions gain new insights from each other regarding strategies to impact health outcomes.[13] This is most recently evidenced in the context of the COVID-19 pandemic, as the mortality and morbidity statistics in the United States and other HICs are more sobering than those in many LMICs, where strong community networks and lessons from previous experiences with health emergencies have contributed to the success of public health initiatives against COVID-19.[14–16] A relationship that promotes bidirectional educational exchange at the level of individual learners recognizes that, although faculty from one institution will have expertise in certain areas, students (traditionally thought of as learners only), community members, and faculty/practitioners from other disciplines and communities also have knowledge and lived experiences to contribute to the learning process. Importantly, a GHE framework that incorporates roles for nontraditional experts and those from different backgrounds will highlight the value of diverse sets of knowledge and change the educational power dynamic.

Conclusion

The COVID-19 pandemic has had a major impact on GHE programs, requiring many to pause learning opportunities and academic institutions to develop new ways to meet learner needs. It is possible, however, that this magnitude of disruption is the catalyst necessary to accelerate changes in the relationships, power structures, and attitudes that have been preventing the field of global health from moving past its colonial foundations. As the pandemic and the calls for the critical examination of global health structures continue, we hope the changes that have already begun will usher in a new era for the field, grounded in equitable partnerships, with a firm understanding of history and a clear vision of health equity goals.

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