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DECOLONISING HEALTH AND MEDICINE

Decolonisation: London's famous school of "tropical medicine" and its uncomfortable identity

One of Britain's most renowned medical institutions is grappling with its colonial history and the effects of racism and inequality on its culture today. In the first of a two part series Mun-Keat Looi asks whether its efforts on decolonisation are enough

Mun-Keat Looi *international features editor*

In 2019 the London School of Hygiene and Tropical Medicine (LSHTM) put itself under interrogation. The school, at the forefront of global health with a leading role in treatments for Ebola, malaria, and HIV, commissioned a two year independent review of structural racism at its heart.[1]

Completed in 2021, the review found that the university's culture and practices "still too often disadvantage people of colour" and that its curriculum remained "Eurocentric." Staff and students from minority groups felt "unsupported" when experiencing or trying to tackle racist behaviours, and they were found not to have "equitable experiences or opportunities to progress at LSHTM." Discriminatory behaviour by senior staff went unchecked because of their influence at the institution, the review concluded.

"While the conclusions of the review are difficult to confront, facing up to them is an essential step towards creating an environment where everyone's contributions and perspectives are valued," says Liam Smeeth, professor of clinical epidemiology at LSHTM who, since the review was first commissioned, has been appointed as the school's director. But what an institution is—and always has been—is not easily changed.

The structural racism review included a separate historical review of the school's foundations in colonialism. It described in detail how LSHTM owed its existence and development to funding, teaching, and research created to support colonialism—and how patterns of racial discrimination and exploitation were established by this.

The review was commissioned under the watch of a previous LSHTM director, Peter Piot, at the tail end of his time in charge. Piot, known as the scientist who first identified the Ebola virus,[2] has himself faced criticism, with some claiming that his memoirs play up his role in Ebola's discovery at the expense of Jean-Jacques Muyembe of the Democratic Republic of Congo and other researchers who contributed to the discovery. This debate is indicative of the way global and public health and medicine—and perhaps science as a whole—have been seen for centuries, with the credit falling to white male researchers from powers such as the UK for discoveries made in its colonies.

The questions now are to what extent history means identity, what should be done in response, and what this says about the wider issue of colonial attitudes at British institutions.

Colonial foundations

LSHTM was founded in 1899 by Patrick Manson, chief medical officer to the Colonial Office, and its training was mandatory for anyone attempting to treat colonial officers working in the British empire. (The British empire spans 400 years, but for the purposes of this article British colonialism is regarded as 1800-1960, during which time Britain took control of India and parts of Africa, among others, until the nations gained independence. "Decolonisation," in the sense of dismantling the empire into independent countries, is regarded in this article as firstly the postwar period of 1945-55 mostly in the Middle East and Asia, and secondly after 1955 mainly in northern and sub-Saharan Africa.)

"In comparison to other British universities established around the same time period, almost all of which are entangled with or have benefitted from British colonialism, LSHTM was established specifically to support the expansion and administration of the British Empire,"[3] wrote Lioba Hirsch, lecturer in social anthropology at the University of Edinburgh and author of the LSHTM report, in an LSHTM blog post in 2021. "The foundation and maintenance of [LSHTM] were made possible through the forced labour and financial exploitation of colonised subjects."[3]

Among the worst known atrocities of British colonisation are the concentration camps used in the second Boer War (1899-1902) and the Kenyan Mau Mau uprising of 1951-60, the latter of which saw prisoners tortured, with some castrated and sexually assaulted.

"Really terrible things happened in the colonial efforts," Smeeth tells *The BMJ*. "That colonial effort had power imbalances, discrimination, and racism baked into it by its very nature. It's not to be hidden, it's not to be pretended that it didn't happen, the fact that many projects and much of LSHTM were founded as part of the effort to colonise parts of the world."

Funding from colonial governments and companies with colonial interests continued to support LSHTM until the 1960s, the school's influence being further

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strengthened by its governance committees, which had representatives from government offices, international health bodies, and private industry, all with British colonial links.

This financial reliance on the Colonial Office—and later on colonial companies and industry—meant that research and teaching objectives were inevitably aligned with colonial interests and that racism and white supremacy influenced its research, teaching, public speeches, and academic writing. For instance, in the 1930s the school "taught and employed several members of staff dedicated to eugenics and its potential to govern British and colonial public health," wrote Hirsch in her 2022 LHSTM report.[4] "During both World Wars, the School was instrumental in protecting British troops against tropical diseases and ensuring the protection of its imperial possessions."

Things changed as the British empire broke up, but the fact that many British experts in "tropical medicine" and public health were required to have studied at LSHTM (or the Liverpool School of Tropical Medicine), not to mention its world leading position in research on these subjects, meant that it retained authority in the new world.

Hirsch wrote in her LSHTM report that "while the School recruited widely from amidst its student body, a student-to-staff pipeline predominantly existed for white male students, most of them British. The latter travelled and conducted research on colonised populations across the Empire. Resultant knowledge was consolidated at the LSHTM in London, further cementing the School's future position as a leader in global public health research and amplifying the epistemic disconnect between the metropolis and its colonies."

Defensive move

LSHTM is just one of many British institutions whose histories are steeped in enslavement and colonialism—from art galleries including Tate to charities and landowners such as the National Trust, financial companies including Lloyds, and publishers such as the *Guardian*—all of which began and grew their operations during colonial or early post-colonial eras and are now finding themselves needing to confront their pasts.

The identities of institutions that were born from this have come under increasing scrutiny in the past decade. Universities worldwide have felt the scrutiny tighten under a civil movement that challenges them to acknowledge rather than gloss over the uncomfortable truths of slavery and colonialism.[5] The covid pandemic and the murder of George Floyd further exposed systemic racial inequities.

"Racism nowadays does a lot of damage in its violent forms when people are verbally abused or physically abused," says Hirsch. "But it does just as much damage when it is very quiet and polite and barely visible to the mainstream white eye."

Commissioning Hirsch's report was LSHTM's move to confront these "barely visible" forms of racism. Of course, it was partly defensive. "Institutions still prefer to have a hold on how these histories play out," Hirsch says, adding that there was a "fear" at the institution that a newspaper would publish something or would dig deep and submit freedom of information requests, such that LSHTM would no longer be in charge of those histories.

Another major driver is staff. "The LSHTM report was not commissioned out of the goodness of their heart," says Seye Abimbola, associate professor of health systems at the University of Sydney and editor in chief of *BMJ Global Health*. "It was commissioned because black and brown people at the school were agitating for it. It was something that LSHTM was forced to do because of the people who were there."

Smeeth tells *The BMJ*, "As director of LSHTM I do what I think is the wise and compassionate thing to do—for the world as a whole, as well as for LSHTM. I guess people can believe me or not."

Hirsch agrees with Abimbola. "There is a genuine curiosity—predominantly staff of colour—pushing for it," she says, adding that staff are not satisfied with merely finding out who had influence over an institution's development and to what extent. "People say, that's not enough. We need, if not reparations, institutional change. We need changes in institutional culture. We demand something."

"Decolonising the curriculum"

LSHTM is working to improve diversity and inclusion, make partnerships more equitable, and "decolonise the curriculum." Smeeth says that this covers all teaching materials, many of which use colonial examples, as well as who does the teaching. For instance, in a practical module on mpox, an example outbreak at a village in a fictional African country has been relocated to a shelter for homeless people in London.

After a lecture on the aetiology of infections, students met a Zika expert (and LSHTM alumna) who led the research response to the microcephaly epidemic in Brazil, teaching the value of knowledge from both research and direct experience. Similarly, before a lecture on eradication LSHTM's students met a polio expert involved in the elimination campaign in India and clinical trials of novel vaccines.

Smeeth tells *The BMJ* that students are now involved in creating teaching content. The school added a lecture on "Colonial Dimensions of Infectious Diseases" and introduced the concept of "decolonising the curriculum" to students in their course descriptions and introductory lectures, while also adding readings on "Decolonising Global Public Health" to the taught materials.

Related to that, says Smeeth, is thinking "again and again and again about what we can do in terms of access to our courses, overcoming barriers to the highest performing courses, and ensuring, as much as we can, not just equity but really overcoming the barriers for bright people who are from either disadvantaged groups or groups with less resources."

LSHTM isn't alone. In 2019 the University of Glasgow vowed to raise and spend £20m towards reparative justice, decolonisation of its curriculum, measures to improve staff and student diversity, renaming of buildings, and scholarships.[6] It also signed an agreement with the University of the West Indies to fund a joint centre for development research.[7] But is that enough?

"Past" is still present

What irks Abimbola is the idea that colonisation is history. "It is not past. It continues," he says. "You can say, 'My ancestors messed up'; it's much more difficult to say, 'I'm continuing their legacy.' I don't think anyone with power is willing to do that just yet."

Covid vaccines are now a classic example. South Africa is among the countries that have contributed to our understanding of covid-19 and the development of vaccines at an unprecedented pace, says Zulfiqar Bhutta, a professor of child health at the Aga Khan University in Pakistan. Yet the imbalance in access to the vaccines is well known, and it continues today. Most countries outside those that are classified as higher income still struggle for access to vaccines or the knowledge and technology that would help them make their own.

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Bhutta explains, "MRNA vaccines came in during the pandemic, but it has taken time and a lot of international effort to get the technology shared with [the vaccines hub started in] South Africa.[8] I would like to see a lot more research and development happening in other low and middle income countries and, to some extent, some reverse osmosis of learning and gains which also derive from experiences in those very geographies who struggle to access the fruits of research."

He adds, "There are many things globally which are happening, cutting edge and advanced—you know, diagnostics methodologies where we would like the fruits of some of those technologies to be available to low and middle income countries as well, and they will not be available on the same kind of parameters in terms of equal sharing of IP [intellectual property], just because of the 'nature of things.' So, we need to work in parallel to ensure that the benefits of technology advances can also pass to those living in geographies with greatest need."

Squaring a colonial past with the "nature of things" today is therefore key. The questions, says Hirsch, are, "Where are we in relation to this past? What has changed? How does the past still have a hold on where we are in the present?"

Hirsch's commission was to cover the 20th century only up to the 1960s, so the report doesn't link the past to the present directly. LSHTM says that this was always the intention—that the first stage covered the period up to the independence era, as this was seen as the vital colonial time. It hopes to complete a second phase covering the 1960s onwards but, although some ongoing research is continuing, there's no current timeline for completion of a new report.

As such, it's difficult to say whether the current actions in response to increasing calls for decolonisation match up to the wrongs of the past. "We are still describing things too much, in my view," says Abimbola. "When people with power ask, 'How are we doing?' we just describe their power rather than challenge its legitimacy."

Bhutta asks, "Decolonisation, yes—but decolonisation for what? To absolve yourselves of the responsibility for global health and centuries of neglect? No. We need more engagement from high income countries into the health, wealth, and wellbeing of countries that are suffering right now in Africa and Asia, and not less. And that does require that we find a middle ground, so that decolonisation does not equate to disengagement."

He adds, "I see such key collaborations and partnerships in other disciplines [such as climate change or the CERN physics research institute in Switzerland]. Sadly, I don't see it in global health yet."

Smeeth says, "The important thing for me is how we want to do things from now on. The world faces many challenges, a lot of them impacting on health in increasingly complex ways."

Certainly, people in the former colonies are now wise to this. In the 16 December 2020 issue of LSHTM's monthly newsletter *Decolonising Global Health*,[9] one academic told of inviting a colleague in South Africa to collaborate.

"She wanted to know—and was testing me, in effect—to see whether I was one of those Northern academics who might claim interest in working 'horizontally' but would later show up to the table expecting to dictate the terms of collaboration, an experience she has had many times before," they wrote. "She asked me, and this is what sticks with me most, to think in terms of my own position vis-à-vis the politics of global health: 'Are you putting the food on the table, sharing the meal, or are you the meal itself?'

"This metaphor was meant as a cautionary tale—don't get eaten up by the very institutions whose power affords you a place at the table but, similarly, don't be dictating the terms of what is served."

See also Feature "What should decolonisation of medical institutions look like?" doi:10.1136/bmj.p2257.
This article is part of a series of articles and podcasts on "decolonising health and medicine": www.bmj.com/decolonising-health

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