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DECOLONISING HEALTH AND MEDICINE

What should decolonisation of medical institutions look like?

A spotlight on race and inequality has highlighted the colonial nature of historic medical institutions. But decolonisation means far more than diversification, finds Mun-Keat Looi

Mun-Keat Looi

"I feel like everything's being decolonised these days," says Lioba Hirsch, a social anthropologist at the University of Edinburgh and author of a study into the colonial foundations of the London School of Hygiene and Tropical Medicine (LSHTM).

"On one hand, that's encouraging because people think it's something worth engaging in or thinking about. On the other hand, 'decolonisation' increasingly means diversifying staff, diversifying students, and trying to close the awarding gap between white students and other students—rather than tackling the root problems it has caused."

So, what else should decolonisation mean?

Ending international outposts

University College Hospital in Ibadan, Nigeria, describes itself as the "flagship tertiary healthcare institution in Nigeria" offering "world class" training, research, and services. Opened in 1957, it fulfilled the long term aim of a commission set up in the wake of independence from the British empire of west African countries. Today it is indeed one of the leading hospitals in west Africa—but the standard it holds itself to is that of its former coloniser.

From the very beginning, even before the Ibadan hospital had been built, the new faculty of medicine founded to deliver the country's workforce of medics was "linked to the academic unit of the University of London to enable Ibadan graduates to obtain the bachelor of medicine and bachelor of surgery degree of the University of London."[1]

"UCH in London was the goal of UCH in Ibadan in Nigeria," says Seye Abimbola, associate professor of health systems at the University of Sydney, "and that logic still underpins how medicine is thought of and practised."

There remains, he says, a trend of setting up local offices of British institutions as a method of internationalisation. "The BBC, for example, can never do for Nigeria what it does for Britain," says Abimbola, "That is very colonial, in my view. It's one thing to be in London. It's another thing to pretend to be local. And by so doing it destabilises local spaces."

Levelling the research playing field

In a 2021 *Lancet Global Health* paper,[2] Muneera Rasheed, a psychologist and global early childhood development researcher in Karachi, Pakistan, wrote about how critical decisions about a study involving investigators from low and middle income countries (LMICs) were often made by researchers in high income countries, who may also undermine the in-country principal investigator by travelling to the site of the study without prior communication; publishing papers or deciding authorship without the knowledge of local experts; or directly communicating with field staff without in-country investigators' knowledge. She also cited cases when "unsubstantiated allegations against the principal investigator" were communicated to the lower income country's university leadership "as a means of coercive influence."

Funding for research is also largely tied to European and American bodies, which hold the purse strings and make decisions based on interests—however well intended—made from abroad and from an identity that is historically colonial.

Speaking at a roundtable discussion on equitable research partnerships held at BMA House in December 2022, Eneyi Kpokiri, clinical pharmacist and assistant professor in social innovation at LSHTM, pointed out that there can be systematic and structural barriers to receiving funding in LMICs. For example, it is currently impossible for researchers in some low resource countries to be principal investigators because of the organisational requirements of some funders or financial regulatory requirements. This makes it difficult to use funding models devised with high income settings in mind.

"Funders need to be aware of national policies or legislation that can create barriers to participation in some countries, and work to accommodate or help change them," she said. "Funders need to be more flexible and look to increase the inclusion of LMIC participants in research operations as well as researchers."

"There are structural problems around money," says Liam Smeeth, director of LSHTM, "And then there's the more subtle, deeper problems, partly historical, around patterns of behaviour and power relationships that are important to acknowledge. This is why it's important to have these things front and centre. Because this is on the back of decades or centuries of people from the imperial nations being in charge."

Equal collaboration

Greater involvement, particularly collaboration between LMICs themselves (often called south-south collaborations), means that those affected most by initiatives to fight infectious disease, the effects of climate change, and sanitation, among other things,

will be at the forefront of decisions affecting them—including committing their own funding and choosing which research questions to prioritise. This would reduce the "saviour" model, where aid agencies and high income countries swoop in and impose solutions they deem right.

"I would like to see leaders in LMICs stand up and be counted," says Zulfiqar Bhutta, a professor of child health at Aga Khan University in Pakistan, "just like they did several decades ago when setting the UN Millenium Development Goals, when they spoke up on the rights and wellbeing of poorer populations in low and middle income countries around justice, education, access to services, and equity."

That's not to say working with higher income countries should be off the table. Instead, Bhutta is at pains to emphasise how it's about truly equal collaboration with equal reason and reward.

"It's only a few decades since we had the unbelievable debate over the ethics of placebo controlled trials in HIV populations [in which to comply with double blinded randomised trial protocols, half the study participants would have received placebo drugs]," he says. "Academia and some people on the ground in LMICs stood their ground, saying, 'You cannot do a placebo controlled trial if you're doing a trial for drug development and testing in my population, just because you believe that treatment would never be accessible to those countries anyway and therefore placebo controlled studies are justified.'

"One of the fundamental principles of decolonisation is that you give equal weight to the quality of life and to the rights of all populations, to the rights of the researchers and the institutions. And, therefore, you create a level playing field around which things can be built.

"If you look at research over the past 50 or 60 years, it's only relatively recently that we see institutions in LMICs drawing a line and saying, 'We're not doing this clinical trial because [the company or country is] doing it for themselves, not for the benefit of populations that we serve or work in.'"

A related point is for more conferences and events to be hosted and planned by the countries affected, rather than higher income countries where visa restrictions have accentuated the problems of access.[3]

Tackling journal influence

The editorial choices of journals in high income countries impact what research people choose to undertake. "There's nothing normal in me conducting a study in Nigeria and wanting to publish it in London," says Abimbola, "It is not normal. It is colonial by definition. Yet somehow we've come to accept that. And it has consequences for the kinds of study that I want to conduct in Nigeria. It's all to impress a guy in London. And the guy in London is completely inconsequential as far as improving anything in Nigeria is concerned."

Abimbola says, "There is a responsibility that the likes of LSHTM, *The BMJ*, or the *Lancet* have—to say, 'Please do not see us as the be all and end all. We are not the arbiter.' They have to say these things because colonised people listen to them."

Alex,* a Ugandan doctor, says that while working in Zimbabwe he submitted a paper to a UK journal which was rejected. Shortly after he moved to the UK he resubmitted the same paper to the same journal with his new address. The paper was accepted with minimal changes.

Giving up power

One step would be visible changes at the top. Would the likes of Smeeth—a white British man—step aside if a suitable candidate from an LMIC emerged? Smeeth agrees that, ideally, the next director of LSHTM would be from an LMIC—if they truly are the best person for the job.

"It'd be a great reflection on the state of world science. Someone from a lower income setting stepping up—as long as there's not a hint of tokenism. For me, anti-discrimination and equity are about fully recognising what someone can bring. And there's no doubt that somebody from a lower income setting, from different backgrounds, can bring a great deal. I would love to see that experience and that depth of knowledge fully appreciated and valued.

"The aim is clear: it's not to pretend that the past didn't exist, but to overcome those patterns. So that people feel and are able to step up and express their expertise, and that competence, and take that responsibility and lead without any sense of inferiority and enter into equal partnerships. I'm not going to pretend that's easy."

It's not about having a particular skin colour, says Hirsch, "Just putting a black or brown person at the top of any of these institutions might not change anything.

"It's about the ways in which we were educated. How we were all taught to comport ourselves in public, what we value, how we can approach things, how we can engage in conflict or disagreements."

Rasheed acknowledges that giving up power "is not easy for anyone, anywhere. Even for people who are not white [but are from the UK or US], for them to give up that power. I don't think it's going to happen."

Hirsch says, "We need honesty and humility to recognise that sometimes we're not the right person to lead a debate or to occupy a position or to lead a campaign. To say, 'I'm going to step aside and I don't need to be involved in everything. I can support the people who should lead this, and I will by making spaces for them, by stepping aside and empowering someone.'"

Such leadership, she says, is especially needed in academia, which is built on the idea of objective knowledge and truth, and confers much value and esteem to historic names as the arbiter of these values.

Says Abimbola, "You have a responsibility to undo that influence because no matter how much I preach to Nigerians, they still look at me like, 'Guy, relax.' But if the *Lancet* says what I'm saying, if [*Lancet* editor Richard] Horton says what I'm saying or if Liam Smeeth says what I'm saying, then it means more. Because the arbiter who may have told them that their work is worth nothing, is instead saying to them, 'Look, we got it wrong.'"

What do the formerly colonised want decolonisation to look like?

There is a bigger question, however. "It's not adequately understood how [people in former colonial countries] want to tackle the power asymmetries between the north and the south," says Rasheed.

"There has to be a lot more clarity about what former colony institutions want to achieve by decolonising, what they're asking for. Are they talking about the challenges that we in the global south have and about giving or distributing power to the people who work here or live here, or who they partner with or collaborate with for global health research? Or is it just about themselves?"

Rasheed emphasises that decolonisation efforts themselves have a colonial face. "It has to come from people who actually live in the global south, they have to be the face of decolonisation. Decolonisation efforts also have to be decolonised."

Abimbola agrees. "I feel that decolonisation is limited to inclusion and diversity: let's have more women, more black and brown people. But the colonial logic that underpins this organisation and institution remains."

The colonial legacy of brain drain

The haemorrhaging of talent is a problem in all countries, but the generational effects on LMIC settings can be catastrophic, particularly for health systems.[4]

A senior doctor in east Africa, speaking under condition of anonymity, says, "I'm training doctors. I'm spending a lot of my time and money training these doctors to be the best in the world. And they are wanted by the UK, for example. But when the UK takes my doctor, they pay me nothing. If they wanted a footballer to come and play for an English football club, they would have to pay millions.

"Decolonisation needs to look at that because our doctors are being stolen. Our nurses are being stolen. The investment in education and health in the UK has dramatically gone down. So now, the higher income countries are turning to LMICs and stealing our doctors, and they're not paying us a penny. This is stealing and must be part of decolonisation.

"When we allow people to migrate from Uganda to the US, France, the UK, it's part of colonialism. How come they don't prevent doctors from entering, but they are preventing migrants from Vietnam, from Burkina Faso, from Niger from crossing? They are interested in educated people. And those who are not educated must be exported to Rwanda."[5]

* Name changed upon request for anonymity.

This article is part of a collection and podcast series on decolonising health and medicine: www.bmj.com/decolonising-health

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