Short biography

Angela Schuster is a physician, epidemiologist and global health expert. Since 2018, she has been working as a researcher and lecturer at the Institute of General Medicine at Charité-Universitätsmedizin Berlin. With a rights-based approach, she focuses on sexual and reproductive health, antimicrobial resistance and planetary health, using qualitative and quantitative methods. Her particular focus is on access to healthcare for disadvantaged and marginalised people in both the Global South and the North. She uses attitude- and action-based transdisciplinary forms of teaching/learning to promote transformative action and the assumption of responsibility in healthcare professions.

Racism and colonial continuities in global health research

1 What is the gap, what is the problem?

Koplan et al. define global health as "a field of education, research and practice that prioritises the improvement of health with equal access for all people worldwide"[1]. Against the backdrop of (post-)colonial power imbalances in global health partnerships, realising this goal is a major challenge for research cooperation between actors from the global North and the global South. Researchers from countries with greater financial resources often have more power and resources than researchers from the Global South. This can lead to unequal relationships and results. In many cases, researchers from the Global North have more say in the design and implementation of research projects and are more likely to benefit from the research results. This is partly due to the fact that research funding is often prioritised in the Global North and that a large proportion of budgets are allocated to institutions in the Global North.

In addition to a lack of financial resources, the issue of time is of particular relevance. While researchers in the Global North finance their research with university funds or project funding, research in the Global South often takes place "after hours" in their free time and in parallel to their actual job. Researchers in the Global South may not have the same access to training and resources as researchers in the Global North. This can make it difficult for them to develop the skills and knowledge required to conduct research to international standards, the majority of which are shaped in the Global North. When global health education has taken place, it has often been in the European or US tropical institutes founded by colonialists and often still characterised by colonialism. Colonial knowledge is thus perpetuated and the colonial attitude in global health curricula, which is much more difficult to grasp, is also internalised and passed on unquestioningly (because it is often implicit) by researchers from the Global South.

Internalised self-stigmatisation and racism can create the feeling of not being up to the task. This can be a major obstacle to active participation in research and lead to feelings of self-doubt and inadequacy, which are exacerbated under time pressure and with intersectional multiple burdens (e.g. gender, sexual orientation). For example, women* and members of minorities in the research community may face discrimination and marginalisation because they do not have access to informal networks that are necessary to build their careers. Project partners in the Global North may have

explicit and internalised prejudices that influence their interactions with researchers in the Global South.

The lack of access to networks and representation is reflected in the proportion of editors-in-chief and leaders from the Global South in scientific global health journals. Only 12% of leadership positions are held by people from the Global South, of which only 4% are held by women*. The lack of prerequisites for the joint development of trust and a suitable collaborative environment can be further challenged by cultural, linguistic differences and differing time resources. Lack of trust in the project partners prevents productive collaboration and knowledge sharing, so it can happen that collected data is not shared due to concerns about lack of recognition or participation. A lack of trust among project partners can also lead to a learned passivity, which becomes established due to the lack of decision-making scope and the right to have a say. 2 What needs to change?

The term global health has been interpreted differently in recent decades. What all the different definitions of global health have in common is that it is seen as an interdisciplinary and multidisciplinary field that encompasses issues that affect the health of individuals as well as at a population level, that require global cooperation and in which health equity and social justice are fundamentally anchored. Global health has a normative character: it is not only about improving the health of people around the world, but also about creating a fairer and more inclusive world. Global health is therefore not just an academic subject or a professional field, but also a value-orientated attitude. As explained above, this normative understanding of global health is not reflected in its practical implementation.

In addition to the contradiction between normative aspirations and practical implementation, there is a lack of participatory process design options that could enable all research participants, including community members, to implement values-based approaches in the design, implementation and evaluation of research projects in practice. Conventional research logics are based on hierarchical structures, competitive thinking and predefined, measurable outcomes. These approaches stand in contrast to a participative approach. In addition, existing training and further education programmes focus on managerial leadership qualifications, which go hand in hand with a strong top-down approach. However, it is not suitable for the complex and challenging environment of global health research, which requires a more collaborative and participatory approach to promote sustainability and accountability. In addition to the negative impact on the process of global health research, the imbalance of colonial continuities affects the efficiency of research and thus the likelihood that it will actually benefit the people who need it.

3 How can things change?

3.1 Sustainable funding

One of the most important measures to combat colonial and racist continuities in global health research is to secure sustainable funding for researchers from the Global South and include targeted funding for Global Health projects led from the Global South. This will help to level the playing field and provide researchers from the Global South with the resources they need to conduct high quality research.

The mandatory linking of a decolonial attitude and practice to the allocation of funding commitments, which are operationalised through a catalogue of indicators, could achieve a more sustainable transformation of the funding of global health research.

3.2 Training of (future) researchers

Anchoring racism as a social determinant of health, colonial continuities in the transfer of medical knowledge and the teaching of colonialism from a medical history perspective in curricula for healthcare professionals is essential. The demands of the Federal Representation of Medical Students in Germany (BVMD) to anchor criticism of racism in the new National Competence-Based Catalogue of Learning Objectives (NKLM) are groundbreaking in this respect [2]. Another important step is the training of researchers from the Global South in the Global South. This can help to minimise internalised colonial ways of thinking that are anchored in global health education in the Global North. By establishing South-South networks and focussing on a broader abolitionism as a theoretical framework for education and training, empowering spaces can be created[3]. On this basis, a new generation of researchers can be created who are able to tackle the health challenges they face locally and globally.

3.3 Representation

Researchers from the Global South need to be represented in leadership positions in global health research organisations and initiatives. This applies both to authorships and to representation among editors of scientific journals. Through the visibility and role model function of these individuals, new generations of researchers can be specifically inspired and motivated to become active in the field of global health research. In addition to these so-called pull factors, targeted scholarships and quota regulations can promote the representation of people from the Global South; intersectional aspects should be taken into consideration here.

3.4 Participatory research

Participatory research is an approach to research that involves all stakeholders, including community members, in the planning, implementation and evaluation of research projects. This approach is important to ensure that the research meets the needs of the communities it is intended to serve.

The prerequisite for implementing participatory research is the mutual trust of all stakeholders. This can be done by creating opportunities for researchers to collaborate and learn from each other, it is important to strongly consider the contextual knowledge of researchers from the Global South and to articulate and address frameworks and opportunities in the joint work of all project partners.

Power imbalances in global health partnerships should be addressed and named transparently. In a further step, it should be ensured that researchers from the Global South have an equal say in the design and implementation of research projects and that they benefit equally from the research results. Participatory process design can be achieved by providing appropriate training and resources and by creating structures and formats for collaboration that support participatory process design.

3.5 Rethinking academic language and terminology

The academic language and terminology used in global health research can be alienating and inaccessible to researchers from the Global South. One reason for this may be that, compared to the

standards set in the Global North, other forms of formal education are learnt and implemented. Secondly, for most researchers from the Global South, English or French is not their mother tongue, but rather the language of the former colonial powers, if at all. Thus, language is an expression of colonial imperialism, which subtly consolidates the political, economic and cultural influence of the former colonial powers.

In order to make language and the reproduction of knowledge more inclusive and accessible and, among other things, to honour the tradition of oral tradition, traditional forms of reproduction in the form of academic publications should be reconsidered or replaced by other more accessible channels of communication.

3.6 Sensitive use of language

Language is not just for information, it shapes our world and can, among other things, unintentionally marginalise. It is therefore important to use language that is inclusive and avoids discrimination. In the context of global health, a sensitive use of language is particularly important because it can help to overcome the legacy of colonialism and racism. More in-depth information on discrimination-sensitive language use in the context of migration and health has been developed by Bilgic et al. and is summarised below[4]. Global health thrives on diversity, which is why generalisations and stereotypes should also be avoided in language; it is helpful to check for discriminatory associations in language. Language is contextualised and changes as society changes. Terms and categories that were once acceptable in a certain context or at another time can take on negative meanings in other contexts or over time and should be scrutinised in this regard. Self-designations, such as the term "People of Colour", which describes non-white people and emphasises the historical oppression of the Black population, should be preferred to foreign designations. Uncertainties and errors regarding the categorisation of certain terms and categories are normal. An open culture of error and appreciative feedback can promote a discrimination-sensitive environment.

3.7 Self-reflective practices at individual and institutional level

Individuals working in global health research should adopt self-reflective practices to recognise and address their own biases and assumptions. The KPSI model (culture, person, situation, institution) can be used here [5]. In order to promote this process at an institutional level, supervision, intervision and further training should take place with this focus, including standardised frameworks for reflecting on and analysing the goals and norms of cooperation [6].

3.8 Raising historical awareness and recognising continuities

Global health has its historical origins in tropical medicine, international health and public health. In Germany, however, the latter did not play a significant role for a long time following its racial ideological instrumentalisation under National Socialism. Only the Ebola epidemic in West Africa and the resulting political interest, which culminated in the German G20 presidency focussing on global health, brought the topic back into focus in Germany. Tropical medicine developed during the colonial period and was used to promote the health of colonised people in order to maintain the economic power and control of the European colonial powers. In the post-colonial period, international health developed on the basis of tropical medicine. While this was formally subject to the maxims of humanitarian aid and development co-operation, it generally focused on combating

individual infectious diseases that could potentially spread and thus affect European economic interests. Today's concepts of global health aim to overcome this legacy by addressing "health problems that transcend national borders and governments and call for action to influence the global forces that determine people's health" [7]. However, different underlying agendas, such as the focus on health security, entrepreneurship, technology, humanities and social justice, challenge commonalities and instead reproduce colonial patterns. The critical categorisation of historical figures such as Robert Koch and Rudolf Virchow is essential for a critical understanding of global health as a branch of science. Koch carried out experiments on sleeping sickness in what is now Tanzania [8] that violated human rights and resulted in deaths [9] Virchow, on the other hand, was involved in ethnological exhibitions and the creation of skull collections, thereby establishing racist paradigms [9]. Furthermore, it is important to look at the ethically sensitive anatomical collections from the colonial era in museums and universities. These collections are not only an important historical document, but also a reflection of the racist and colonial thought patterns of the time. However, there is a considerable backlog in terms of both high-quality research and the development of teaching materials. The didactic reappraisal and culture of remembrance of the crimes committed in the name of public health during the Nazi era is exemplary for the academic examination of colonial health history.

Sources / Literature

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