BIZCOMMUNITY

Global health still mimics colonial ways: here's how to break the pattern

By Madhukar Pai

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Imagine this scenario. A couple of newly minted Master of Public Health graduates from an African university, say in Rwanda, land in Washington DC for a two-week visit. They visit a few hospitals, speak to a few healthcare workers and policymakers, read a few reports, and write up a nice assessment of the US health system with several recommendations on how to fix the issues they saw. They submit their manuscript to the American Journal of Public Health.

High-income country trainees and experts must learn to listen and be humble. Shutterstock

Can you imagine the journal even sending it out for review? Even if the paper got published somewhere, would US health researchers take it seriously? (They should, I suppose. After all, the broken US healthcare system needs all the help it can get.)

Clearly, it's an impossible scenario yet American graduates land in low-income countries to advise them on global health issues all the time. I met an African expert recently and she expressed her frustration about how American "kids" with little or no experience come all the time to "advise" her government on what to do about health.

American graduates aren't the only ones accused of such global health consulting malpractice. It happens with all high-income country folks. And it is not just naïve rookies stepping into advisory roles. The professionalised consulting industry, such as McKinsey or Bain, and NGOs such as PATH or CHAI, as well as and donor agencies send high-income country "experts" to low- and middle-income countries to offer "technical assistance" when they might know little about the countries they are advising or the problems they are trying to fix.

This problem of consulting malpractice is merely one facet of a larger issue of how global health, even today, is still colonial in many ways, and how high-income country experts and institutions are valued much more than expertise in low- and middle-income countries. Analyses of research studies' authorship show that high-income country authors dominate and lead publications even when the work is entirely focused on or done in low- and middle-income countries.

While parachute research is increasingly being discouraged, there is little discussion about parachute global health consulting.

To be clear, I am not against consulting or technical assistance. Nor am I against high-income country trainees visiting low- and middle income countries for global health. They are mostly well-intentioned. Also, we do not want to discourage young people who want to do good. But I do believe things can be done better.

Based on a recent thread I posted on Twitter and the dozens of responses, here are 10 crowd sourced ideas on how consulting can be improved.

Ten ideas

1. Global health courses must discourage global health voluntourism, and guide trainees and graduates on what they must NOT do, when they go to low- and middle-income countries. How NOT to save the world must be a critical, required component of all global health courses. The principle of *do not harm* must be reinforced in all training. The recent story of an American woman with no medical training running a centre for malnourished Ugandan children is an excellent case study in global health clinical malpractice.

2. Those studying or working in global health must complete a course or book on the colonial history of tropical, international and global health. I recommend Randall Packard's book, "A History of Global Health." For a more gut-wrenching account of colonialism, I suggest "King Leopold's Ghost: A Story of Greed, Terror and Heroism in Colonial Africa."

3. Predeparture training by global health programmes must go beyond what vaccines to take and also include content on cross-cultural effectiveness and cultural humility, bidirectional participatory relationships, local capacity building, long-term sustainability, and respect for local expertise and leadership. Training in privilege and allyship is also critical. Above all, high income countries trainees and experts must learn to listen and be humble.

4. Consultants must have lived and worked in low- and middle-income countries, preferably, in the same countries they will be advising. A two-week trip to South Africa does not make anyone an "Africa expert." As Randall Packard put it

> *"Everyone involved in global health decision-making should be required to work in the countries and see howthings look from the ground level."*

5. Consultants should be careful about going beyond their specific content or country expertise. It is perfectly fine to decline consulting invitations that are a poor match with skill sets or country-specific experience.

6. Before technical assistance is offered ministries of health in low- and middle-income countries should be consulted on whether they need assistance, and what specific expertise and prior experience/background they need. If there are local experts who are suitable, they could be contracted to provide technical assistance instead of expensive consultants flown in from high-income countries.

7. Strengthening global health capacity in the Global South and expanding the cadre of national experts is key for

weaning low- and middle-income countries away from the current dependence on high-income countries experts. This is an opportunity for high income countries institutions to demonstrate reciprocity. Schools of public health and research institutions in high-income countries have an obligation to host, train and send back talented low- and middle-income countries researchers and experts. The NIH Fogarty International Center could be a model for other high-income countries.

8. There is no reason why good training and capacity developmentcannot happen in low- and middle-income countries. Building top-notch schools and institutions in these countries and developing world-class expertise within them is key. A few recent examples include the Public Health Foundation of India, BRAC School of Public Health in Bangladesh, the University of Global Health Equity in Rwanda, and the Africa Health Research Institute in South Africa. The Africa CDC, Nigeria CDC, and African Society for Laboratory Medicine are examples of technical agencies. Initiatives such as the Emerging Voices in Global Health have empowered researchers from the Global South by providing skills training and facilitating their participation in global health events.

9. The ultimate solution is to challenge the current architecture of global health and work towards "decolonising global health". This includes answering uncomfortable questions.
Why are global health institutions, donors, and power structures invariably based in high-income countries or controlled by their experts? Why is the flow of funding, people and knowledge unidirectional (north to south)? What colonial practices have led to the heavy dependence of lower-middle income countries on aid and technical assistance from their former colonisers? Why are major decisions in global health made in Geneva, Davos, New York or Seattle when those who deal with the real issues and have solutions are not at the table (or struggle to get visas, even when invited)? And why are global health meetings held in high income countries when the real problems and expertise are elsewhere?

10. The entire global health consulting industry needs a serious re-think. As Teju Cole wrote:

> *If we are going to interfere in the lives of others, a little due diligence is a minimum requirement.*

In the end, when strong global health leadership emerges from low- and middle-income countries, the role of external consultants will need to evolve. High-income country experts will have to see themselves as enablers and *accompagnateurs*, not "fixers."

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ABOUT THE AUTHOR

Madhukar Pai, director of global health and professor, *McGill University*