

Rethinking Knowledge in Global Health

79

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Abstract

In global (public) health, the way we define knowledge and knowers is not neutral and directly affects the outcome of health interventions. The COVID-19 pandemic highlighted both the limitations of the current knowledge ecosystem in global health and the positive impact of nationally and locally informed public health interventions. From this perspective, this chapter aims to increase readers' understanding of these limitations and guide them in efforts to improve interactions between and within diverse knowledge systems.

This chapter is divided into three main sections. Firstly, we briefly illuminate the roots of decolonial science in global health and the importance of social sciences in public health practice. Secondly, we describe common biases that act as barriers to change in the global health knowledge ecosystem and introduce a change management approach to rethink the way different forms of knowledge

are currently generated, understood, used, disseminated, and legitimized. Thirdly, we define the concept of Emancipatory Health Interventions (EHIs), the role of global actors in their design, and present a case study to guide actors in efforts to identify existing EHIs and normalize practices in the future.

Keywords

Global health · Decoloniality · Decolonizing global health · Global health equity · Knowledge cultivation

79.1 Colonial History in Global Health Knowledge Ecosystem

79.1.1 Introduction to Decolonial Science

Throughout history, those seeking to expand colonial missions used public health as a façade of benevolence to disguise their true motivations [1]. “I now firmly believe in the tropical colonisation by the white race...” were the words of Patrick Manson in 1900. As the father of tropical medicine, Manson arguably founded global health education.

Global health architecture still mimics its colonial origins [2]. Gender (men) and ancestry

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(white European) dominates and dictates funding streams, authorship of publications, leadership of agencies, composition of boards, editorial board positions, awards, and even participants at “international” conferences. In institutions, systems of privilege are sustained by processes and practices rooted in saviourism instead of agency [3]. In practice, the COVID-19 pandemic response underscored how systems of power, hidden behind calls for “generosity” over equity, ensured a prolonged pandemic and limited the expected impact of vaccination in LMICs [4].

Global health is not neutral, reciprocal, diverse or equitable. Global health is not global.

Disrupting the current global health architecture does not aim to introduce a new definition but to move beyond the binaries that oppose Euro North-American regions (i.e. Global North) considered as the norm from other regions (i.e. Global South) by creating space for different ways of doing and being to co-exist and flourish [5, 6].

In *The Black Pacific: Anti-Colonial Struggles and Oceanic Connections* (2015), postcolonial researcher Robbie Shilliam defines decolonial science as the *cultivation* rather than the *production* of knowledge. He argues that knowledge production is an imperialist endeavour that aims to prolong and accumulate knowledge so that (post)colonized people can only consume or extend someone else’s knowledge of themselves while *knowledge cultivation* is a creative process that requires actors to reflect on the past and centre themselves in the matter of their inquiry. Fostering *knowledge cultivation* offers a pathway towards acknowledging the past wrongdoings, unlearning entrenched negative practices, and embracing a future rooted in self-reliance that matches the historic aspirations of decolonization movements.

79.1.2 Brief History of Global Health Education Colonial Origins

Global health education’s history is indissociable from theories around the supremacy of the white race that underpin racism and served to justify colonialism and its legacies. It continues to bear

(harmful) assumptions so engrained that they have long been mistaken for facts [7, 8]. While decolonial studies, critical development studies, critical race theory, and whiteness studies offer a lot to global health, many students have never been introduced to these fields.

Global health originates from colonial and tropical medicine, created during colonialism as an effort to protect the health of white colonists and keep indigenous population used as labour force alive. Following political decolonization (i.e., independence movements), it was renamed international health with a novel emphasis placed on the notion that formally colonized actors were incapable of addressing their health issues without the “development or technical assistance” or “aid” of former colonizers.

It was Frantz Fanon who first defined global health as a system where public health is used as a colonial tool to westernize the world.

The doctor always appears as a link in the colonialist network, as a spokesman for the occupying power.

His work provides a framework to facilitate our understanding of the current asymmetries of power and privilege in health as well as the origins of the resistance emanating from Global South actors, indigenous communities in the Global North, and people with Global South ancestries living in the Global North [9].

The COVID-19 pandemic underscored the importance of Fanon’s work to gain insight into the limitations of global health responses in the absence of active mechanisms to transcend global health origins and make it actively anti-supremacist, anti-oppressionist, and anti-racist [10]. At the global, national, and interpersonal level reaching health equity worldwide will only be achieved by actively working towards applying a decolonial lens to health globally [11]. This, in turn, will require us to address how knowledge is legitimized.

79.1.3 How Can we Foster Knowledge Cultivation?

Rather than defining national boundaries or a specific category of actors, this chapter aims to

guide public health actors over the world, passionate about achieving health equity to answer the question: how do we rethink the way we interact with different forms of knowledge? This approach is guided by the words of Paul Farmer:

Global health is not a discipline or a field but rather a collection of problems

The way we generate, understand, use, disseminate, and legitimize knowledge is intertwined with our culture and geographies. The current knowledge hierarchy—inherited from colonial administrations—that assumes the superiority of “Western scientific knowledge” (i.e., Euro-North-American) and Global North experts over ancestral and Indigenous ways of knowing and experts in and from the Global South hinders innovation and progress in addressing health inequities [12]. To inform the design of fit-for-purpose interventions and policies that meet the specific needs of diverse communities, public health actors must break these hierarchies and learn how to foster knowledge plurality—a system that learns from and equally values every form of knowledge derived from all regions.

In this chapter, our decolonial approach to rethinking knowledge in global health aims to normalize the design of health interventions liberated from colonial hierarchies of knowledge and knowers and which reflect the collective power and agency of people to determine their own destiny. We called them Emancipatory Health Interventions (EHIs).

An in-depth discussion of colonial legacies and the debates around global solidarity/cooperation is beyond the scope of this chapter. However, additional reading is referenced [13].

79.2 Critical Steps to Understand and Change the Current Knowledge Ecosystem

79.2.1 Common Barriers to Knowledge Ecosystem Change

Change is not a moment, a task, or a checklist. It is a process. Before diving into our three-steps

change management approach to addressing asymmetries in the current global health knowledge ecosystem, we identify some common barriers to change.

- *Problem blindness*—Just because some practices are common does not make them acceptable. Actors’ inability to properly name issues is a barrier to change. Problematizing the normal means naming and stigmatizing issues to allow collective solutions to emerge. For example, the Black Lives Matter and Decolonising Global Health movements did not introduce new issues but rather—through social media—increased access to terminologies (for example, intersectionality, epistemic injustice) from social sciences scholars working at the intersection of colonialism, racism, and health.
- *Framing bias*—Public health issues can be linked to behaviour and/or environment which means that framing should never be limited to the notion that a group should mimic another that is seemingly “performing better”. Doing so effectively negates the role of culture, socio-economic, gender, sexual orientation, and potential differential access. The way we frame issues inform the approaches chosen. For example, talking about *hard-to-reach groups* versus *hard-to-reach services* often activates different public health responses. The former places the onus on communities and the latter on the public health system. The more distant one is from an issue/community, the more likely they are to misdiagnose or misrepresent them due to lower contextual, cultural, and practical understanding of the constraints of communities at risk. It manifests when actors in the Global North promote policies or conceptualize issues in a way that is disconnected from the realities of communities in the Global South (i.e., “Debates” around remunerating Community Health Workers).
- *Ignoring positionality*—Actors’ understanding of health issues is informed by their proximity to the environment of communities at risk. The academic literature is only the collection of what has been written by those who

have been historically granted access to publications in academic journals (e.g., mostly Euro-North American scholars) rather than the sum of all knowledge on a specific context. Here, bi- and multi-cultural actors—including diasporic communities—who work at the intersection of the Global North and the Global South (also known as double agents or brokers) can play an important role in reducing the gaps between national/local versus international understanding to address framing biases [14].

- *Analysing problems and not successes:* There is a tendency in the Euro-North American scholarship to approach changes in terms of *what is not working and need to be fixed* rather than *what is working and how can it be reproduced*. Successes are not best practices but instead reflect the way an intervention functions at its best. Analysing and sharing successes are a way to show communities at risk that things can be done differently and give them a sense of what changes would mean for them in practice. Additionally, by placing their environment rather than theories at the centre of the change through learnings from other communities closest to them, positive outcomes become more relatable which ultimately increases sense of ownership. Here, the objective is to normalize pre-defined outcomes rather than scale up.

In summary, the current knowledge ecosystem is contaminated with conscious and unconscious biases. Thus, moving towards embracing all forms of knowledge cannot be achieved without critically thinking about what is currently taught, how it is taught, and the positionality of the teachers.

79.2.2 From Saviourism to Unleashing Agency of Communities

To the question “why did you choose the field of global health?” students often answer, “I want to help”. While compassion and altruism are central in efforts to reach health equity globally, global health should no longer be a “safe space” to enact

saviour fetish of “helping”, inherited from colonialism [15].

Global health education is not neutral. In 1970, in the *Pedagogy of the Oppressed*, Paulo Freire described how a teacher, by simple virtue of having power over the curriculum, the dispensation of knowledge and what is allowed to be taught can influence how students think with respect to values, attitudes, and beliefs. When students and communities are expected to be passive recipients of “knowledge” and interventions with no say in design or content, agency is removed, and the “help” becomes a tool to oppress voices in societies [16].

In this section, we define saviourism as all practices, policies, and attitudes that reinforce privilege and power by placing the perspective of the “saviour” above the agency of communities. The saviour or charity model implies that the right to health is given by others (e.g., licenced or donated) rather than taken by communities to make sense of their world in their own terms (e.g., emancipatory) [17, 18]. An excellent contemporary example is vaccine donations as the way to achieve COVID-19 vaccine equity rather than a TRIPS intellectual property waiver and technology transfer that would allow countries to make their own products and be self-reliant.

Saviourism is displayed when actors:

1. Do not question the origins and legitimacy of current asymmetries of power.
2. Do not challenge the parameters set by those who are not affected by the issues (e.g., global health priorities, intellectual property laws).
3. Prioritize quick fixes that create an endless cycle of reactions rather than allowing structures and systems to learn and adapt by focusing solely on what is achieved rather than how it is achieved.
4. See global health as charity, aid or philanthropy, rather than equity, justice, reparations, and solidarity.

Reaching health equity requires a paradigm shift that removes the control over the content and type of knowledge from the hand of the “teacher” and instead promotes agency to enable students/communities to construct their own

meaning through experience within their socio-cultural contexts.

Unleashing the agency or self-determination of communities at risk means moving towards self-regulation of the learning [16]. These communities should no longer be used as a mean to implement interventions and policies largely already designed by people who are far removed from their environment. To move beyond this subject/object relationship, public health actors globally should invoke the ability of communities at risk to understand their problems better than anyone else, actively engage with resources, accept responsibility, take control of, make mistakes in learning, and see how those choices impact their lives [17].

79.2.3 From Hierarchies of Knowing to Global Public Health

The idea of global health as an academic discipline and a field reinforces hierarchies of knowledge and knowers and disconnects health interventions from their regional/national/local public health systems. The distance between those who define and have the power to shape the agenda and those whose lives are impacted by these issues continues to maintain avoidable, unfair, and structural inequalities between actors.

Can a field be “global” when it is primarily taught in the Global North and therefore, the expertise relies on geographies and ability to afford costs of attendance (e.g., tuition fees, cost of living, visa)? What differentiates global health actors from national public health actors in countries which are the targets or intended recipients of global health interventions? [19].

Rather than attempting to answer these questions, we are introducing the concept of *global public health*. It is neither a new name for global health nor a novel discipline. It is the acknowledgement that health is indissociable from the social, cultural, economic, historic, and geographic specificities of a country. While current global health practices and policies places others before communities, applying a *global public health* lens demands that the design of health interventions be always informed by those impacted by the issues and led by those whose

lived experience and positionality is closest to the realities of the communities being served. It breaks hierarchies of knowledge and knowers by centring the voices of national public health actors and defining global health actors as enablers or allies whose role is to facilitate knowledge sharing and global cooperation.

79.2.4 From the Foreign Gaze to Reconnecting Knowledge to its Context

The foreign gaze is a concept coined by Seye Abimbola to describe entrenched power asymmetries in global health partnerships between the actors who fund and set the agenda and the settings where the research and interventions are conducted. It reflects a disconnect between knowledge and their social, cultural, economic, and geographic context that seems to shift the responsibility to address health issues on “others”. When the value of data and knowledge is based on parameters set by others rather than the impact on communities, it weakens communities’ ownership of these issues and its consequences.

Who we imagine we write and work for (i.e., gaze), and the position or standpoint from which we write, and work (i.e., pose) informs the success of global health interventions [20]. Recentring public health work towards the local/regional gaze is key to addressing health inequities globally.

79.3 Freeing Public Health Interventions from Colonial Legacies

79.3.1 A Framework to Reimagine Global Health Knowledge Ecosystem

The design of health interventions freed from colonial legacies starts with delinking entrenched assumptions that development, progress, and modernity are synonyms with the westernization of the world [21]. It is about fostering the natural

evolution of local ways of doing in a way that contextualize the idea of health as a fundamental and inalienable human right [8, 22, 23]. In Table 79.1, we presented some of the ways in which coloniality currently manifests in the global health knowledge ecosystem and proposed solutions to improve interactions between knowledge systems in the future.

79.3.2 Defining Emancipatory Health Interventions and Example in Practice

We define emancipatory health interventions as projects where the:

1. Data are collected with the primary aim to increase and expand the knowledge of people on the frontline and the communities at risk as

opposed to addressing “gaps in the literature”.

2. Design of the interventions is driven by people with lived experience, in the communities at risk or those closest to them as opposed to foreign actors.
3. Communities at risk and those closest to them are encouraged to develop products and tools specific to their environment first rather than attempting to answer to “global needs”.
4. Demand for the interventions, and assessment of their successes and failures is articulated by the communities at risk or those closest to them as opposed to international donors’ agendas.
5. Monitoring of projects is primarily designed to support communities at risk learning and advocacy efforts in the long term rather than for compliance to donors’ reporting requirements.

Table 79.1 Reimagining global health knowledge ecosystem interactions

Current global health knowledge ecosystem		Re-imagined global health knowledge ecosystem	
Coloniality of power	Institutions and actors in the Global North control financial resources, health research and health policy agenda, as well as knowledge prioritization decision-making	Capacity strengthening and sharing with local, national, and regional health actors with onus placed on local, national, and regional health organizations to set health agenda. (e.g. reinforcing the role and voice of national public health experts, agencies, and regional entities like Africa CDC over “international” organizations)	Unleashing the agency of community
Coloniality of knowledge	Perceived inherent superiority of euro-north American ways of doing and knowing over “others”	Foreign knowledge should be complementary to national knowledge systems rather than seek to assert its dominance and/or try to erase them (e.g. integrating traditional healers in health interventions, designing contextualized community mental health interventions, acknowledging the origins of health interventions like mindfulness beyond the foreign gaze, recognizing the contribution of “othered” knowledge systems to euro-north American model)	Reconnecting knowledge to its context
Coloniality of being	Legitimized superiority of euro-north American knowers mirrored by the legitimized inferiority of non-euro-north American knowers. Binary of modern/rational/civilized versus traditional/irrational/uncivilized	Knowledge systems should be equally valued, studied, and respected. (e.g. diversify teaching and learning to include global south led interventions like the friendship bench in Zimbabwe (see case study below), COVID-19 vaccines manufactured in low and middle-income countries, Ife medical school of primary health care in Nigeria, Indian & Chinese Indigenous medical systems, etc.)	Fostering global public health

Public health interventions should enable people with lived experience, communities at risk and those closest to them to speak for themselves and advance their own struggle. Recentring public health interventions towards the local/regional gaze is key to addressing health inequities globally.

A practical example of what we recognize as an Emancipatory Health intervention is the Friendship Bench intervention [24]. Zimbabwean psychiatrist, Dixon Chibanda built from his knowledge of its context and community, collaborated with national and international actors, and used foreign knowledge systems and resources to develop a fit-for-purpose and contextualized intervention that meet the needs of the communities the intervention aimed to serve. Beyond the internationally recognised success of this intervention, current attempts to normalize its unique approach to mental health support in both Global South and Global North settings underscore the importance of community ownership in the success of public health interventions.

79.4 Conclusion

Rethinking knowledge in global health is a process of unlearning and challenging harmful conscious and unconscious practices and processes in the current knowledge ecosystem to create space for diverse knowledge systems to flourish. This change cannot be summarized into tasks and is better understood as an intentional and continuous process to critically engage with the dominant teaching and learning environment until currently other(ed) knowledge systems can co-exist, develop, and freely generate the knowledge necessary to address the issues of the communities they represent.

We believe that this novel global public health environment, centred around the cultivation of knowledge, shared learning across countries, between and within communities, will enable the design of the Emancipatory Health interventions needed to address health inequities and make sustainable changes worldwide.

Any public health actors can contribute to the emancipatory project, but foreign/distant/Global North actors cannot be the drivers of emancipation. They need to start with confronting their past, reflecting on their gaze and humbly working towards building trustworthiness and allyship rather than relying on saviour tropes that demand blind trust, unchallenged obedience and reinforce power and privilege by removing communities' agency.

Disclaimer The views expressed in this article do not necessarily represent the views of the organizations the authors work at.

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