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Decolonizing global health curriculum: from fad to foundation

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Introduction: Increasing calls have been made to decolonize global health education but there has been a lack of consensus and clarity on how this should be done. We conducted a qualitative study to understand current educational programs and curricula that aim to educate public health and allied health students to increase awareness of how colonialist structures of power influence current global health practice and provide students with tools to decolonize global health. Our goal is to inform related curriculum development and provide recommendations.

Methods: We conducted key-informant interviews with 14 study coordinators and faculty from institutions of higher learning with global health programs who are involved in developing educational approaches. All interviews were audio recorded, transcribed, and analyzed using an 'up from the data' approach.

Results: Participants varied in their understanding of decolonizing global health and recognized that there is a lack of guidance in the field; this has an impact on how curriculum is developed and taught. Participants described a range of decolonizing global health educational activities in the classrooms and in applied learning activities. Most programming was situated in Diversity, Equity, and Inclusion Initiatives and participants did not always feel this was the best 'home' for such work; to some this reflected a lack of institutional support. Other institutional barriers included lack of protected time for faculty and limited budgets for speaker honoraria, co-creation, and related teaching expenses.

Discussion: Institutes of higher learning can play an important role, either positively or negatively, in decolonizing global health education. At a minimum such institutions should financially support faculty to incorporate decolonizing global health in their pedagogy and strengthen scholarship towards common understandings. More substantive institutional support is needed however to meaningfully transform institutional relationships that actively support equitable partnerships, co-creation, and responsiveness to local community priorities.

KEYWORDS

global health, pedagogy, curriculum, teaching, decolonization and education

1. Introduction

Global health education is rooted in settler colonialism and a white supremacy mindset (Packard, 2016; Binagwaho et al., 2022). The field's origins have contributed to the perpetuation of neocolonialism, knowledge erasure, and unequal power dynamics within global health (Shah et al., 2019; Jensen and Lopez-Carmen, 2022; Naidu and Abimbola, 2022). Discussions around how to meaningfully transform the field of global health education and address the underlying white supremacy mindset have recently proliferated (Binagwaho et al., 2022; Kwete et al., 2022; Naidu and Abimbola, 2022). A comparative review specifically explored approaches to "decolonize" curriculum and pedagogy in higher education, which range from recognizing constraints to disrupting and making room for alternatives (Shahjahan et al., 2022).

Despite these discussions, there are indications that the field of global health education is significantly lacking in its efforts. This is evident in Opara's call to "decolonize the decolonization movement," which calls attention to specific concerns with the decolonization movement in global health. Namely, "the urgency dictated by white guilt leaves little space and time for actual reflection, deconstructing, deconditioning, relationship-building, and structural dismantling." This urgency leads to insufficient critical power analyses and the continued perpetuation of colonial mindsets within decolonization movements (Opara, 2021).

A recent scoping review also highlighted the inadequacies of anticolonial education in global health. Collective understanding of a global health curriculum with sufficient focus on anticolonialism is lacking, and there are limited publications demonstrating work in this space. Among these limited publications, there is a focus on the individual student and their awareness rather than pedagogy, structural change, and the experience of faculty and global health partners. In addition, a continued focus on experiential learning via short-term experiences in global health (STEGHs) raises concerns, as these experiences are often one-sided and extractive (Kalbarczyk et al., 2020; Perkins et al., 2023).

The authors recognize that not all educational initiatives or approaches are published in peer reviewed literature (Bhakuni and Abimbola, 2021), and additional approaches are needed to better understand the current scope of decolonizing global health education. We conducted a qualitative study to understand current educational programs and curricula that aim to educate public health and allied health students to increase awareness of how colonialist structures of power influence current global health practice and provide students with tools to "decolonize global health." We sought to assess the extent to which global health programs address topics related to decolonizing global health and understand the educational approaches being used.

Our goal is to inform related curriculum development and provide recommendations and lessons learned. Research on the current state of the field and innovative approaches is particularly important to build a repository of resources for academic leadership and faculty in global health (Perkins et al., 2023).

2. Materials and methods

We conducted key-informant interviews (KIIs) with study coordinators and faculty from institutions of higher learning with global health programs who are involved in developing educational approaches for teaching health professionals and public health students about decolonizing global health.

2.1. Participant recruitment

We used two strategies to identify and recruit participants. First, we conducted an online search to identify instructors and coordinators of courses with publicly available syllabi that addressed topics related to decolonizing global health. We emailed these individuals directly requesting an interview and/or requesting they connect us with others who may have expertise in this topic. Then we sent a call for participants via the Consortium of Universities for Global Health (CUGH) listserv. CUGH's membership includes over 182 academic institutions and partners in more than 39 countries; the CUGH network spans roughly 30,000 global health professionals worldwide. Interested individuals were asked to respond to the study team with their information and a brief statement of experience related to teaching decolonizing global health. The study team assessed each respondent's eligibility and then followed up to schedule an interview.

2.2. Conducting KIIs

Eligible participants were contacted via email and asked for their availability for a 60-min interview to be conducted via Zoom. Each participant reviewed the consent form and gave their consent verbally prior to the start of the interview. Interviews lasted 35–75 min. All interviews were audio-recorded; the study team also took written notes during the interview.

2.3. Analysis

Recordings were transcribed by a third-party transcription service, Rev.©. All identifiers were removed from transcripts prior to analysis.

Data was analyzed using an adaptation of Richards' "Up from the data" approach. Transcripts were closely read by each analyst (SR, AK, and SP) multiple times, followed by annotations, detailed note-taking, and open coding. Analysts regularly wrote individual and collaborative memos to reflect on the process and held group sessions to iteratively define and apply codes and link data (Richards, 2015). Findings arose out of these memos and group sessions, and transcripts were re-visited considering defined themes.

2.4. Positionality and reflexivity

As a team of researchers, we recognize that this research requires a critical examination of our positionality and how it may shape our understanding and interpretation of decolonizing global health. Decolonizing global health is a complex and nuanced topic that encompasses a range of issues, such as colonialism, neocolonialism, power imbalances, structural racism, and structural inequalities.

The research team employed several approaches to continuously engage in reflexivity, examine positionality, and mitigate potential biases. Interviewers (SR and MR) consciously used active listening techniques to ensure that participant perspectives were heard and

accurately represented in the data. Following interviews, interviewers (SR and MR) reflected on their positionality via memos, including thoughts on interviewing techniques, interpretations of the data, and dynamics within interviews. Analysts (SR, AK, and SP) wrote memos throughout the analysis process to reflect on the coding process and their interpretations. While our individual experiences and perspectives influenced how we formed connections and made sense of the data, we hope to provide a nuanced and inclusive understanding of the current state of educational approaches for teaching decolonizing global health.

3. Results

We conducted 14 KIIs with participants in various stages of their global health education careers.

3.1. Defining decolonizing global health in education

Across participants there was a wide range of interpretation on the definition of decolonizing global health education and how to operationalize it.

> *We're still not clear about the difference between decolonization, diversity, and anti-racism. KII 13.*

> *I designed all these debates about what is decolonizing global health? Is it possible to decolonize global health? Which are the challenges? Which are the possibilities? What are we meaning by decolonizing global health? KII 09.*

Participants described difficulties with a lack of evidence-based curricula and set of "desired results" from an evaluation standpoint. Lack of clarity around metrics and expectations has made it more challenging to implement decolonizing global health education initiatives.

> *I do think that one of the biggest challenges in this kind of work is really understanding what it means for a learner to come out of the curriculum and have had the desired result, because I think the desired result is challenging. KII 03.*

Participants' work in this area was often situated within Diversity, Equity, and Inclusion (DEI) initiatives, which were also the most common funding source mentioned to support this work.

> *We have our DEI agenda, which is about diversity, and there's a decolonizing agenda and there's an overlap between them. But they are not the same thing; they feed off each other. KII 07.*

> *Understanding the difference between diversifying* versus *decolonization, where diversification is still giving, keeping the power and the hands of whiteness, how much to diversify and who to invite to allow the diversification* versus *decolonization is taking the power away and distributing the power… KII 11.*

> *We had a DEI network of staff…and that group started to reflect on the issues of coloniality in global health and in our own institution. And we are pointing to this kind of overlap between DEI and decolonization. It got a much stronger impetus in the aftermath of the murder of George Floyd. And in terms of education, it was people saying, "how is the global South represented in our teaching? Why are all of the examples from former colonies? Where are the examples from Latin America, from Asia? KII 07.*

One DEI training course at their university helped a participant to reflect on their teaching and practice from an identity point of view.

> *When I started lecturing in global health it was like, how do we reflect on what we bring to a different setting, and how might that not matter, and how might it matter? And how can you be aware of that so it's not something that really catches you off guard? KII 12.*

Another participant reflected on the racial and ethnic diversity within their institution and how this affects global health teaching.

> *The fact that the profile of our staff at the institution is predominantly white affects what we teach, how we teach it, how students feel in a classroom, what they see and experience as being expertise and power. KII 07.*

3.2. Motivations for decolonizing global health education

Participants were asked to describe their motivations for decolonizing global health education. Eight participants mentioned being driven by ethical considerations. For some this shift was driven by a desire to challenge colonial roots of global health and promote a more equitable and mutually beneficial approach to health initiatives.

Others described missed opportunities for bidirectional learning and partnerships. They noted that educators are becoming increasingly aware of the need to challenge this paradigm and encourage more bi-directional approaches and collaboration.

> *I think a lot of that [issues with global health] has to do with our one directional teachings of global health, and the maybe missed opportunity to think in reciprocal terms about how we can learn from less resourced countries or places where we are actually physically sending our students. Instead of just prescribing what we feel global health means, we need to learn more directly and less indirectly from different populations. KII 10.*

Participants specifically voiced a desire to prevent future leaders from perpetuating existing approaches by ensuring they are equipped with necessary skills, and one participant anticipated that systemic change will be furthered by future generations, starting in schools.

> *I think we are training future leaders in global health. And if we miss this opportunity to teach this kind of mutual learning now, then these future leaders will perpetuate the same kinds of neo-colonial issues that we are seeing where the global north has been prioritized*

> *in leadership in global health organizations. And there's certainly more male leadership. KII 10.*

> *I think we are going to see more change. I really do…. I think it's going to start in schools… And then I think it's going to slowly penetrate to some of the other places. KII 03.*

Some individuals were driven by their own personal experiences and identities. For example, one participant identified as one of the few minorities at their institution and described their personal experience moving between a 'colonial' country and a 'post-colonial' country, and the importance of 'decoloniality' in both contexts.

> *People are moving on, people are talking about post-coloniality. I'm not sure if I fit in this system of post-coloniality because I live in two separate worlds. I'm moving between a colonial system and a 'post-colonial system'. So this is one motivation to address coloniality itself…Decoloniality is about resistance, it's about colonial legacy, it's about exploitation, it's about undoing all the things linked to coloniality. I might not be able to resist physically but I think the ability to resist the colonial legacies, or the ability to undo some of the things that affect minds–this is interesting to me because it is personal. KII 13.*

3.3. Educational approaches to decolonizing global health education

Course approaches related to teaching decolonizing global health ranged widely, from an introduction, framing, or guest lecture to an entire course dedicated to the topic. One participant voiced the idea that increased dedication to this topic was warranted.

> *This topic needs more attention. This could just be a whole course and instead of it being a 40-min lecture tacked onto something. KII 12.*

Specifically, presenting systemic issues without a discussion about history, meaningful reflection, or action is lacking.

Some participants described first steps or entry points such as expanding reading lists to include authors from LMICs and Indigenous communities. One participant discussed inclusion of theories relevant to decolonizing global health education throughout course content, such as Wallerstein's "world-system" theory (Wallerstein, 2011), dependency theory (Frank, 1966), Freire's consciousness raising theory (Freire, 2005), and Fanon's contribution to critical theory (Frantz, 2021) (KII 01).

Another participant noted that while addressing course reading lists is a good start, it is important for researchers to collaborate with varying partners on the development of the content itself. This ranged from co-creation with students, to exploring bidirectional approaches and mutually beneficial partnerships.

> *We want [students] to have more voice in the content of what we deliver, in the way that we deliver it. We want them also to bring in their experience. We want them to understand that learning is a mutual experience. KII 13.*

> *Teaching these kinds of courses… bringing both practitioners as well as scholars together to talk about, "So what would that look like? How would we decolonize the research? How do we decide even the research questions are biased, they are based on what our interests are? So how do we ensure that those questions are relevant to the countries where we work? KII 01.*

> *How do we partner with those people to help them address and get their healthcare needs?… we are not the rescuers, that's not our goal at all. For lower resource countries, we want to help them build capacity in any way we can, but it's really to learn about what they do well in their systems… Are there things that we can take away? Are there things that we can give to them? A collaboration on providing the best type of… care across the globe. KII 05.*

However, another participant cautioned that bidirectionality may not be the ideal approach in every situation and explored responsibility within their partnership.

> *Part of the purpose… is to make it actually not as bidirectional because it should not be the responsibility of my… colleagues to train my trainees how to not be jerks. That should be my responsibility. But I think what's hard is that I also do not have all of the content expert of what it looks like to not be a jerk on the field. So we try to, as they had the bandwidth, get their perspective, but then create a curriculum where certainly international partners can be involved, but they do not have to feel the burden of having the decolonization conversation with US-based trainees. KII 03.*

One participant acknowledged the differences between what a student is learning, and what is being modeled in the institution around them to further discussion and understanding.

> *What should be the partnership according to these decolonial approaches… How can these debates also contrast with what you are living in the field or in other discussions in class? KII 09.*

Participants generally agreed that it was important to expose students to diverse methods of teaching and learning delivery, from classroom readings and theory, as mentioned previously, to immersion and applied learning. Participants discussed increasing exposure and immersion as linked to learning, and two participants specifically discussed the importance of participating in experiential learning within your own community (i.e., decolonizing global health takes place within countries or communities as well as between countries or communities).

Participants offered case studies, including examples of power negotiation, as useful tools for applied learning, specifically in relation to self-awareness during travel and immersion.

> *"Our focus is more practical examples. And specifically, I can think of case studies that we go through… that, hopefully, will mitigate any of those feeling of superiority… And again, these are those reducing that decolonized view of what global health is, and really focusing on learning from your partners and being true, yeah, equitable partners." KII 04.*

Participants also spoke of the importance of reflection, embedded throughout the learning process.

> *Reflection is absolutely critical for decolonization in general. So, I would say that decolonization is something that requires regular reflection and reflective practice. So, I make sure the students complete reflective journals every week. DGH 11.*

> *Students write a six-page reflective, essay, focused on their positionality in global health regarding the discussions held during the quarter… they could ambition their future career in global health considering the debates we have had here. And where can they focus, how can they contribute if that's part of their interest to decolonize global health, considering their future careers as well. KII 09.*

One participant also encouraged acknowledging and making space for the time and energy required to meaningfully engage with this work.

> *It takes a lot of time. It takes a lot of emotional and mental energy. KII 11.*

3.4. Institutional barriers

While participants were enthusiastic about their efforts to decolonize global health, they reflected on systems- and institutional-level challenges to doing this work.

Some programs struggle to embrace change because of existing processes and regulations, such as those set by accrediting bodies. One participant mentioned that they cannot make important changes to their program because the accreditation board has already approved the existing curriculum.

> *Our program at the moment… is accredited, and so we cannot fool with it a lot, because the accreditation board has already approved what we are doing. KII 14.*

One participant felt that there was a lack of institutional will to enact change.

> *There are some institutions that are oblivious by choice, meaning global health wasn't really on their radars or they want global health enough to be able to recruit [trainees], but it's not their big thing. And then I think that there are institutions that, while they may not be openly telling their faculty, 'You cannot participate in [DGH curriculum]', but they will never endorse [DGH curriculum]. KII 03.*

Four participants saw this lack of institutional support reflected in a lack of funding. This includes faculty time, speaker honoraria, and teaching expenses.

> *That workshop is very expensive to run. And we have been trying for years to get our institution to say, 'We'll let you have a peer-to-peer grant workshop for global health where you can focus on grants and that work in the global setting.' That would be one example where money is a huge barrier. KII 02.*

Others felt that their institutions were trying to support decolonizing global health initiatives although very slowly.

> *I think the institution is trying, working really, really hard on its colonial roots… It's late, very, very, very, very, very late. But they are working hard on it. KII 06.*

One participant believed that large organizations in charge of global health education, such as the Consortium of Universities for Global Health, should take on a leadership role and standardize practices and teaching so everyone is on the same page. Others reflected on the importance of such standardization since people are in very different places regarding decolonizing global health within this field, and it can be hard to move these conversations forward, particularly with decision-makers.

At a systems level, many participants reflected on the colonial systems and structures of global health, including funders and multilateral organizations, and noted that the field cannot be decolonized until they are.

> *…a lot of the people who run the system are based in Western countries. And those people in Western countries, be it government, be it UN, be it large NGOs are not decolonized themselves. So until they decolonize their own minds, they can talk about DEI and they can talk about anti-racism and they can talk about decoloniality, but they'll never actually be able to do it. KII 06.*

4. Discussion

Institutions of higher learning can play a major role, positively or negatively, in decolonizing global health education but there is lack of clarity on how best to approach this scope of work. In our study we found some participants focused on applied learning experiences such as study abroad and STEGHs while others described classroom-oriented approaches such as addressing reading lists. None of our participants described existing initiatives designed to transform institutional structures that uphold colonial systems. Junior faculty may be engaging more with this work but may also have less power to influence larger systems and structures. This may lead to the various definitions and approaches evident in our study.

Many of our participants described the additional effort this work takes and noted that there was limited institutional support (i.e., funds for salary) for faculty to engage in decolonizing global health education. Protected time for teaching has been widely cited as a barrier for faculty in health education amidst competing priorities (De Villiers et al., 2018; Stadler et al., 2020; Couper et al., 2023). Institutions at a minimum should provide protected time to faculty interested in teaching decolonizing global health and should support their scholarship to standardize definitions, approaches, and methods of evaluation and establish next steps. Some faculty may be peripherally interested in incorporating decolonizing principles into their pedagogy and content but do

not know how, or even where to start (Perkins et al., 2023). Universities may also consider providing protected time to faculty across different Departments who can support others and offer concrete examples on incorporating decolonization into pedagogy, syllabi, and content.

We also found that DEI Initiatives tended to be an immediate, if sometimes imperfect, home for decolonizing global health work. Today's DEI landscape in Higher Education includes managing campus climate flashpoints, building equitable recruitment processes and retention resources, implementing initiatives that shift institutional culture towards belonging for all, and creating meaningful internal and external partnerships. Other ongoing considerations include upcoming legislation that could potentially jeopardize DEI efforts across public and private institutions, and remaining flexible enough to pivot and redirect energies, support and resources around emerging incidents of ongoing harm and trauma as they relate to Black, Indigenous, and people of color and other under-represented groups in our institutions and society.

The terms 'diversity,' 'equity,' 'inclusion,' 'anti-racism,' 'belonging,' and 'decolonization' are sometimes used interchangeably by institutions to denote DEI initiatives. These concepts have evolving definitions, and while inter-related in practice, they also represent distinct outcomes. Both DEI and decolonizing initiatives require an understanding and acknowledgement of institutional power structures, systems of oppression and marginalization, and intersectionality. Both can serve as agents to challenge and dismantle inequities. These initiatives can be well-aligned, but using the different terms interchangeably without nuance can present some challenges.

Decolonization efforts embedded within a DEI office may benefit from existing funding mechanisms and internal/external relationships, and staff that is invested in advancing these initiatives. However, situating decolonizing initiatives within DEI offices may also require staff to build additional capacity, skillsets, and expertise in frameworks and strategies that intentionally center unpacking colonial bias. Offices that are equipped to support DEI initiatives but are also assigned decolonizing education efforts (as an add-on) are balancing finite capacity and resources (funding, personnel, etc.) while managing competing priorities and expectations. In such cases, it is critical to assess the strategic, consistent inclusion of a decolonization lens and mission to prioritize resources and accountability for these initiatives.

Our study also speaks to current engagement with capacity-building and local solutions to problems within global health education. While some participants described course content related to these topics, there was limited systems-level (i.e., institutional level) engagement with bi-directional learning and teaching or course co-creation. While participants were aware of the importance of moving away from short term or extractive relationships with LMIC partners, there were few examples of how academic institutions were promoting this outside of the classroom. Binagwaho et al. (2020) suggest embedding community-based education into university programs where research projects are co-created and reflect community priorities. They also argue that we must strengthen institutions in LMICs through financial investment and partnership strengthening initiatives such as faculty exchanges and targeted training based on the needs of the institution (Binagwaho et al., 2020). Existing approaches to research partnership evaluation may also be adapted to articulate "desired results" and evaluate implementation of community-based education (THET, 2023). But institutional barriers remain for developing such programs and for addressing institutional partnerships rooted in colonial structures. Kulesa and Brantuo (2021) enumerate three such barriers including an overemphasis on intercountry relationships, implicit hierarchies, and ethical dilemmas (Kulesa and Brantuo, 2021).

Given the depth and breadth of work required in this space to meaningfully transform educational systems, and ensure this movement is not a trend, institutions must meaningfully invest in their educational pillars. This will mean supporting faculty to transform the design of their courses (from syllabi and reading lists to core concepts, tools, experiential learning approaches and applications), to explore and define their pedagogy, and co-create novel approaches with a global cadre of experts.

4.1. Strengths and limitations

Our primary recruitment method was a call for participation via the CUGH network with over 170 academic institutions and other organizations around the world. While membership to CUGH may be both institutional and individual, we may have missed key stakeholders conducting this work who do not have access to this network. Further, given limitations of the research team, we were unable to interview individuals who do not speak English.

5. Conclusion

More work is needed to build consensus and guidelines on how to incorporate decolonization in global health education in the classroom and within institutes of higher learning. At a minimum, institutions should financially support their faculty to do this work and enhance scholarship in decolonizing global health education through protected time or incentives. Ultimately though these institutions need to invest in educational partnerships to co-create and co-offer programs that are responsive to community priorities.

Data availability statement

The datasets presented in this article are not readily available because they may be identifiable due to the content discussed in the KIIs. Requests to access the datasets should be directed to AK (akalbarc@jhu.edu).

Ethics statement

The studies involving human participants were reviewed and approved by Johns Hopkins Bloomberg School of Public Health Institutional Review Board. Written informed consent for participation was not required for this study in accordance with the national legislation and the institutional requirements.

Author contributions

AK and SP conceptualized the study and supported the data analysis. SR conducted data collection and initial data analysis. MA authored discussion on DEI. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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