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Decolonising global health through transformational learning?

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We thank Hirsch(1) for her incisive commentary on efforts to decolonise global health institutions and the exigency of moving beyond tokenistic initiatives and showy commitments to diversity. The flattening of entrenched colonial-era power hierarchies is essential to ensure policy, education and research is informed by perspectives from the very communities they affect. Yet these hierarchies are propped up by historical biases that formed, and remain deeply embedded in the very structures of our institutions .(2) It is tempting to invoke a conceptual framework for decolonisation through top-down initiatives, but such taxonomies should arise from paying attention to the narratives of people who suffer from the prejudices which have arisen through colonial regimes. These are not limited to racism but also classicism, sexism, ableism, xenophobia and gender discrimination.(3)

Structural inequalities are designed to re-enforce power imbalances. Before systemic change can occur, sources and concentration of that power must firstly be laid bare through educational reflection that prompts political will and collective action, what Freire (1973)(4) refers to as critical consciousness. This requires marshalling techniques to overturn unconscious biases inculcated through the hidden curricula of global health education and training. Moving beyond unconscious bias training, we would encourage global health institutions that are serious about decolonial work to invest in programmes to facilitate transformational learning, providing time and space for learners to encounter more deeply the cognitive dissonance of confronting one's own biases, evaluating structural discrimination within their institution, and comprehending the lived realities of the individuals they seek to serve. These models should be developed by ethnocultural minority members of high-income countries (HIC), working in tandem with populations in low and middle-income countries (LMICs) and integrated throughout any global health curriculum/ training programmes.

One example of this is Cultural Safety, a bottom-up model developed in New Zealand to address health inequalities experienced by indigenous Maori populations.(5) Cultural Safety aspires to give more agency, power and leadership to historically marginalised communities., addressing health issues prioritised by them and in line with their cultural values.[5] Such innovations in education may help pave the way for true, palpable change in the field of global health. By being honest about the difficulty of engaging with decolonial perspectives – and the psychological inertia that precedes the cognitively taxing task of undoing one's deeply ingrained narratives about the world – we may move forward in efforts to decolonise, and radically transform, our disciplines.

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