EPISODE 10: ACTIONS FOR DECOLONIZING GLOBAL HEALTH

Garry Aslanyan [00:00:07] Hello and welcome to the Global Health Matters podcast. I'm your host, Garry Aslanyan.

Garry Aslanyan [00:00:12] Many of you who work in global health know that there is growing momentum in global health research to support the creation of research ecosystems that is free from residual colonial practices and thinking. Of course, the majority of low- and middle-income countries have achieved independence and have been decolonized. But yet there remain tensions in global health research and practice that hold back fully country-owned and country-led initiatives. Scientists in countries, and particularly in Africa, have taken a leading voice in this discussion. So today, to take a deeper dive into this topic, I'm going to be joined by Catherine Kyobutungi, who is the Executive Director of the African Population and Health Research Center in Kenya. And my second guest will be Agnes Binagwaho, who was the Minister of Health of Rwanda from 2011 to 2016 and is currently the Vice-Chancellor of the University of Global Health Equity in Rwanda. I have no doubt that the viewpoints that we will gather from Catherine and Agnes will make for a very thought provoking discussion. So welcome Catherine from Nairobi and welcome Agnes from Kigali.

Agnes Binagwaho [00:01:37] Thank you for having us.

Catherine Kyobutungi [00:01:38] So happy to be here.

Garry Aslanyan [00:01:39] Maybe we could start by you sharing with the audience what was the inspiration that led you to pursuing a career in health and global health. Let's start with Catherine.

Catherine Kyobutungi [00:01:53] I was born and raised in Uganda. I studied in Uganda and went to medical school at the Makerere University and finished medicine and was posted to work in the middle of nowhere, really. This was a small health facility. No phones, no internet, no running water at the time, we used to use rainwater. No reliable electricity. And I spent three years of my life in that environment. But my turning point was saving a little boy who came with severe anaemia and had had repeated incidences of malaria, and persuading the parents at that time to buy a bednet. They even had to save money and suspend paying the medical bills at this hospital until they could afford a bednet. I was able to help that family work through financial difficulties. A bednet at that time was about $10 equivalent, but we were able to work through that and they were able to buy a bednet, and I was able to talk to this woman for hours until she understood what she had to do to protect her baby from repeated attacks of malaria. And every time I remember when I went to the Outpatients and found this little boy climbing over the seats with a baby and the mother. Every time I remember, I get emotional because the mother had ...; they were not sick, she had just come to show me that the baby had survived, was now a toddler, and she had another baby. And she told me, never in her life had she ever had more than one child at a time because all her children were dying of malaria when they were infants. And so for her to have a second baby, to have two children at the same time, was such a big thing for her that she felt she owed it to me, so she had come to show me her baby. And of course the toddler was alive. So for me,

that was the turning point, and I think it affected my orientation towards public health as opposed to clinical practice.

Garry Aslanyan [00:03:52] Thank you so much, Catherine, for that. Agnes, what's your journey?

Agnes Binagwaho [00:03:57] My journey is somehow simpler. It all started because I wanted to be a healer. I was a little girl. And after that, I became an adolescent and I still wanted. Because I grew up in Europe and I was educated to stay there forever. In 1996, I decided to come back and finding a health system that has to be rebuilt was totally different than coming and using my skills immediately. This was a tipping point. When I was in Europe, I would just say, I need an incubator for a child, hm, this – "wait, it was coming in the ward a couple of days later Here, I need to learn so many things, the specification, the wait, everything. And after that, I need to learn how a system is made. We don't think so much when we work in a system that is working, that there is a system where you are just part of it. Before starting to work as a paediatrician, it was a long time ago, HIV was still a nightmare because there was no treatment in Africa, very little capacity to diagnose, and no system to treat HIV and AIDS. And so I focused my attention to children affected by HIV and AIDS and the right to access care because what was needed in Africa existed in the world, but we didn't have access to that. So it was a breach in our human right to health. So children, HIV and AIDS and human rights was what I was doing, clinically and also mobilizing to get access to health services. And also at that time, it was just after the 1994 genocide against the Tutsi, the health sector was not functioning, many people have been killed or fled out of the country, and we had to rebuild everything. So with colleagues we started to rebuild it, we started at the same time we were fighting to get access to (can't decipher word)HIV. And from then, I entered in global health because I went to the global arena to fight for the creation of a global fund, etc., to provide access to HIV treatment and diagnostics to Africans.

Garry Aslanyan [00:06:55] This episode was inspired by recent articles written by both Catherine and Agnes, drawing attention to the challenge that impedes the achievement of a decolonized health research enterprise. In each article, they propose actions that can constructively move forward and get us to achieving healthier and more equitable research systems. Catherine, you are part of a group of African researchers who wrote an open letter highlighting this residual colonial legacies in research. Maybe you could briefly share with our audience what prompted you to take this action and to take up this issue?

Catherine Kyobutungi [00:07:36] Yes. What prompted us to write the letter, we call it a letter right now because it actually got legs and it has resulted in a lot of changes, even in such a short time. So I think things add up over time and this letter was written at the time after all of us had been battered by the pandemic. And in the middle of the pandemic last year, there was also this Black Lives Matter movement. And after the world witnessing on camera George Floyd's life being snuffed out of him, I think a lot of people really had some self-reflection about the kind of world we live in, where somebody's life could be snuffed out, in view, in front of other people. And so it prompted a lot of self-reflection in global health practitioners, funding agencies, and there was a lot of debate and discussion and initiatives on diversity, equity and inclusion. Institutions change their policies and they set up new strategies. So this

is the context in which this letter was written. And then lo and behold, we are sitting there, we are very active on Twitter, and somebody whom I'd never met, but now we are like allies, tweets something about an organization in the U.S. making an announcement about how they had been awarded $30 million in a consortium of partners to do some work on building capacity for malaria. And the announcement had seven institutions. There were four American, two British and one Australian. And so out of these seven, there was not one single African organization. And these were the lead partners, and they were supposed to build capacity of national malaria control programmes in 18 African countries. So that was the question. Was there no single African partner who could be part of this event, that was named on this partnership. So we started tweeting, we created a real tweetstorm. And then we got a response and the response said, yeah, we're going to work with local partners. That is not the point. Why are there named partners and then those who are not named who are sort of anonymous and you are going to work with them? What is this thing that seven organizations outside Africa are going to do to build capacity? Then it was, we are going to train national malaria control programmes to design tools to collect data and design studies and analyse it. And I was like, wow, in every African country there's a school of public health that has capacity to do this work. If you give US$ 30 million to 30 universities in Africa and each of them got one million dollars, the impact they would have is greater than you are going to see from this kind of skewed initiative where maybe 70% of the funding is going to go for overheads and it will never reach the national malaria control programmes. So how is this possible that after everything that has happened at this time, this is still acceptable? So he said, no it's not. So after this tweetstorm, we met on Twitter and said, OK, can write a letter, and that's how the letter came about.

Agnes Binagwaho [00:10:51] I want to congratulate Catherine, and I want to give her as an example that enough is enough, and all the tools can be used. Here it was Twitter and Twitter made a storm and this letter they wrote, starting with Twitter, has advanced the agenda of a fair partnership. I love that, Catherine.

Catherine Kyobutungi [00:11:18] I have to say it was surprising the kinds of results we received when they said, let's put the letter in Nature, I was like, who reads Nature? Then, all of a sudden, I'm getting e-mails from all over the world. That letter, that letter, that letter. I mean, when the letter was published the response was overwhelming. Everybody said, this needed to be said and thank you guys for saying it.

Garry Aslanyan [00:11:39] Agnes, I know you do not like to use the term decolonization.

Agnes Binagwaho [00:11:43] People love to call decolonizing. And for me, the colony, you know, we have Lumumba and Nkrumah, so many people who died to be colonizers and it has a meaning. It's a legal situation of a country without independence. We have independence, but it's something else. And it's the tale of colonization, yes, but it's simply white supremacy. And this is what we see with our colleague because it's all start years, centuries ago, because the white supremacy is the pillar of what has brought slavery and colonization. They did so because Europe believed that the white at that time, they create a theory, they didn't believe that because if we go in history at that time, they didn't believe that white was superior. But to justify the colonization, they theorized that we were inferior, our religion was inferior and

that they are there to save us so that the white people in Europe start to believe it and believe that the colonization was good for us when the colonization has only one objective, to steal our land and our riches and to kill all those who opposed to it. That's how we face many genocide that were not, never reported. So the movement to take colonized global health, it's OK, but I prefer that it's a movement to fight white supremacy in global health. And that's how I name it. And it's a structural issue because our partners, the people we are working very well with, really believe that they can help us in malaria programme design when we are the experts. And there are people who have good hearts and good meaning and everything, and they really believe they can help us. So they believe also that we are inferior. They don't trust our school of public health. They don't trust our knowledge. And they trust that we they will manage better for us when doing so, more than 60 percent of money will remain there and not serve the purpose for which they received the money. So they are also part of the white supremacist system. Because white supremacy is more a philosophy and practice than the colour of the skin now, but it's based on the same pillar that have allowed slavery and colonialism, and we need to fight that mindset.

Garry Aslanyan [00:14:31] Interesting, Agnes, thank you. Catherine, how do you relate to what Agnes just shared and in terms of the vision to transform the research ecosystems in, well, in this case in Africa, because both of you are working in Africa?

Catherine Kyobutungi [00:14:46] So I think I have similar sentiments regarding this decolonization debate, but maybe a slightly different perspective as well. And since I'm a researcher, I see the global health system as having different parts. But a big part of that is what I would call the knowledge system. So because the knowledge system in a way sort of supports now the practice. And so there are lots of things which are broken. But I think fundamentally we need to change the knowledge system in global health because a lot of it rides on, the practice rides on the knowledge now. And why? I think one thing that Agnes said which I found compelling is that there are different types of global health practitioners. There are those who believe, yes I want to change the world. But that whole supremacy, the coloniality, the “saviourism” comes in and people see themselves as saviours. They see themselves as the people with solutions. So when they come, they never, ever think that the people they're trying to help could have their own solutions. And so the knowledge system supports that because how do you define the problem? You do a literature review. You review literature done by people in the same system. You never ask the people, what is your problem? You do a literature review that is the sort of system there and then you decide what the problem is. And if something is not supported by the literature, then it's not the problem. If something is not supported by the literature, it's not the solution. But where did the come from? You never asked the people. You came up with some system, collected some data and then defined. You keep on defining the wrong problems and you keep on defining the wrong solutions because you never listen to the people who will tell you what their problem is. So that's the first thing. Now the other people for whom global health practice is a career. So it's a career going somewhere. Whatever it is, wherever it takes them, they are OK. So you finish your Ph.D., you write 200 papers, they give you a professorship, you write more papers, then you get, I don't know what else, you write more papers. And so you throw papers somewhere in the universe, and somehow that is rewarding because the more papers you write, the more promotions, the more grants. So for them, global health is a career. So it doesn't matter what

the actual problem is, their career interests take precedence. And these are the same people who, during such a profile, the profile is defined by the knowledge they've thrown out there in the universe. How many papers they've published, what kind of traffic did they have? They're the ones who get the influence, they're the ones who get the ear of now the funding agencies. When the funding agencies are funding the programme, they go back to the knowledge system, what does the literature say? So as I said, the knowledge system is a big part of that.

Agnes Binagwaho [00:17:32] If people in Africa dealing with COVID successfully, because in Europe they didn't deal with it successfully, write a paper, they will not be published in the system if they don't associate themselves with people who do nothing in the U.S. So this is a white supremacy system and I can show you for COVID. It's incredible how people who didn't really succeed, have published and how people who are working on the ground and did things in Africa are not.

Catherine Kyobutungi [00:18:05] The COVID experience has been very eye-opening. Almost a year into the pandemic, I read a story where some public health experts from the US were going to Germany to learn about contact tracing. I was like, what? Contact tracing, like the art that has been refined, developed by Africans who are trying to fight Ebola. But they are going to learn about contact tracing in Germany, a country that has never done any contact tracing, maybe before COVID. But that's it. And I kept on asking myself, the first few months of the pandemic, there was this whole thing, Africa is not as badly affected as it has been, but almost nothing like, OK, what is Africa doing right?

Garry Aslanyan [00:18:53] We have an episode on this, both Catherine and Agnes, on COVID in Africa. And in fact, these are the kinds of things we open out there and discuss. Why Africa has actually seen much better response through continental policies and coordination between countries. So to our listeners, we really looked into that and it's clear that you have the same sentiment. But Catherine, going back to your letter, you refer to partnerships with northern institutions that are often fully equitable and dignified they are not. And you wrote that this type of funding has also contributed to a model of implementation that puts the delivery of several health interventions directly in the hands of Western organizations, which further diminishes the capacities and ownership of national programmes to deliver to the populations, and ultimately leads to weak health systems and lack of sufficient local capacity. So what does an equitable partnership look like to you, Catherine? And how can we ensure this is realized?

Catherine Kyobutungi [00:20:14] So I think when I think about equitable partnership, we have to look at it in the conceptional way. What can be done immediately? But then the fact that this system has undermined capacity within the region, we have to look at the long term. So there are things we can do right now, and those are some of the things we are challenging, that funders, funding agencies, regardless of who they are, should not accept "partnerships", should not accept "initiatives" that don't have local institutions on them. Because, as I've said, for some people, US$ 30 million is a career, for me as an African doing research in Africa, I don't have anywhere else to go. I have responsibilities, I have a mandate, I have relationships with government, I have relationships with civil society. I'm never going to do a project and

after three years, I move on and I go somewhere else I'm there. If I move, my institution is there. So investing in institutions like ours means that we are able to execute our mandate, we are able to work with these partners, whether they are government or civil society, knowing that we have an aim to solve this problem. We're not going to get a grant because it's something we're going to put on our CV and it's going to look good and then it will help us get a bigger grant. So that's the conception of things that there have to be ways of assessing initiatives that go beyond the quality of the technical work, that look at equitable partnerships, that look at pathways to impact, that look at the involvement of voices on the ground, whether they are institutions like ours, whether they are policy-makers or civil society. That is short term. Long term, because I see this model. The way the global health funding model is set up is, as an African institution, it's almost impossible to bid and win a grant from the U.S. Government. Because the grants are $30 million, they are $70 million, $150 million. You can count on your fingers how many African institutions can absorb $150 million, perhaps there's none. So if you keep that model of saying, you're sort of setting up local institutions for failure, because no one has the infrastructure to bid for $150 million and then deliver it with the kind of burden that is put on the institutions for accounting, for reporting, for finance. So the system is set up for African institutions to fail. So our proposal is: funding agencies, regardless of where they are, need to invest in African institutions as partners because the current model may have delivered some results, but it's an expensive model. If you give $30 million and $20 million of it is left in overheads and staffing in northern institutions, and only $10 million comes on the ground, if this was an African institution, maybe $25 million would actually go into programming and the $5 million would be overheads. So it is a very inefficient model, and if global health partners are interested in impact and in success and efficiency, then the model of giving money to northern institutions to come and work with local partners as sub-grantees is flawed. It's never going to give us the results that we want. So in the long term, we need funding agencies to work with African institutions so that 10 years from now you have people who can absorb $150 million.

Agnes Binagwaho [00:23:38] I was in the National Control Commission, Permanent Secretary, Minister, it's a fight to help them to build systems. They are ready to teach you how to give a pill, but not to create the system for sustainability. Now, I think there is an opportunity to change, but we need so many changes. We need to eliminate the North-South paradigm in research that essentially benefits the Western world. We need also to treat the researcher the same way, they come from high- or low- income country, recognize their production and ensure that research questions are proposed by the priorities of the low-income countries when it's research to be done in low-income countries. And co-design. Yes, it's not that we are against partnership. We are for equal, respectful partnerships where we work together, as Catherine said. We teach, but we teach beyond the management, create systems, but also grant writing, article writing and also how to go for the next research. Create a system. You create a research, make sure that this research is embedded in the development of the country. Create a way to collect data, to store data and to make them to share that with other researchers across country and inside the country. So there is a lot of things to do. But change the current paradigm. Or, give the money, create partnerships for sustainability and not for you to exist only. It has to be two ways.

Garry Aslanyan [00:25:30] Agnes, you also referred to the education system and as another key area, and I know you also had your own article published in the British Medical Journal recently, where you mentioned several challenges to be addressed in reforming education. So this is to both of you. Where can we start doing that and what are the issues that need to be put on the table in terms of reforming education, preparing the cadres and institutions? Maybe both of you can reflect on that.

Catherine Kyobutungi [00:26:06] It's one of the things I was going to mention about my own perspective about the decolonization debate. And one of those perspectives is the fact that decolonizing is like saying, I colonized now I am decolonizing. And so we are still the recipients of goodwill for people who want to dismantle a system that does not benefit us. That's my big problem with this decolonization thing. So my sense is, in every system you need to start somewhere. So the system exists as it is. But even though the system exists, we need to think about: How do we break the cycle? How do we break the cycle? Very soon after starting, we need to ask ourselves what is the role of the people who have been colonized? What do we need to do ourselves, not what needs to be done for us to be decolonized? And so that's where the capacity comes in. That's where the education system comes in because, I was recently saying that the pipeline is very unhealthy. Our education system is still steeped into colonial practice. Our history, our geography, our orientation, because as Agnes said earlier, our knowledge systems were destroyed. Now when this knowledge system that perpetuates coloniality, and therefore, if we are to break this, then something's going to take us a generation. But we need to go very far back. What does our curriculum teach our kids? What are our kids being taught about our place as Africans in society and in the world? That is something that is much more long term. But in the interim, for me, in the next few years, I want to be part of an African movement for equity. I don't want to be part of a global movement to be decolonized.

Agnes Binagwaho [00:27:59] I'm not colonized, so don't lose your time to try to decolonize me. But also we need to equip the people in our continent to be able to learn and to do research. To have the equipment and the environment to do that. Create system, equip people, teach them in Africa how to do good research for Africa. Don't take them, pretend educating them in Europe. In fact, to have a brain drain canal so that many of the Africans stay there. Bring systems here and education in Africa and we will see what you bring, outcomes to be measured. If not, you just continue to develop the Western world.

Garry Aslanyan [00:29:19] So another area we have to kind of look at again in this discussion is the role of country and country governments and trying to, not to be over-relying on external funding, and have this continuation of risky situations where that really cuts or changes could affect. So what can be done by national institutions, governments in countries, to strengthen funding of research of capacity, education, institutions?

Catherine Kyobutungi [00:29:59] Of course, we live in the part of the world where government investments in research and developments are very low. So we can blame our governments for not investing enough in research. But then on the other hand, my perspective is that as a researcher, I have to ask myself, What can I do? Because there are many explanations. You can find long, long, long explanations of why governments are not.

And my hypothesis is that as African scientists, as African academics, we have not adequately, consistently demonstrated the value that we bring to government in terms of knowledge production and the purpose that that knowledge can be used for. Because academics and researchers are part of the global knowledge system, so we do research, we publish papers in The Lancet and then we call a meeting and we disseminate and we go back home, we get another grant. So the connection between academia and government is very weak in many institutions, in many countries. And so government, when you tell them that perhaps a school of public health needs $100 million every year for research, the Treasury's asking themselves, Okay, what are the returns on this investment? Because with $100 million maybe they can put up three different hospitals and then they can win the next election. So that's the connection. Our failure as academics and African researchers to demonstrate the value that research brings to the government, I think, is where we need to work.

Garry Aslanyan [00:31:34] Agnes, what's your view on this? How can we make country investments more tangible and help go away from reliance and overreliance on external funding?

Agnes Binagwaho [00:31:47] But first, do what Catherine said. You know, research now are done because we have replicated the Western model that research are for publication first, for improving life after. And we don't do necessary research to improve policies or to help the government to improve policies. In my country, it's a little bit different because I don't say that investment is what level I appreciate. But, because policies are made evidence-based, the government is interested in research. So I prefer to reform the money as it is now , do research that serves new policies that are more equitable, more inclusive and more oriented to development. And so with the development, with the growing of our countries, more will be invested in research.

Garry Aslanyan [00:32:52] So this is a very, obviously, complex problem and we have touched upon really some of the key themes and we've only probably opened the discussion today, was what we are dealing with was created over centuries and decades, and that there's clearly no quick fix for it. But in our efforts and individual efforts, both of you clearly are working towards this, thinking differently about the issue or taking small steps and vision. You both mentioned to actually see action and see how this can be powerful. In conclusion of our discussion, so our audience can take away some parting thoughts from you on how we can inspire them to start driving change with their research institution, in where they are working, with their programmes and projects and environments where they are. Maybe, Catherine, you can start first.

Catherine Kyobutungi [00:34:04] So I think if I was to give maybe a parting shot, I would say two things. And I'll elaborate on those two things. One is that with the change that you want to see, and then the second is that power is never given, power is taken. No one who has power, regardless of what form of power, is going to willingly give it to you. So you have to recognize that and then trying to build your resources, your resilience, your capacity to take. So even that's part of the decolonization debate. The colonizers are not going to cede power. Supremacists are not going to cede power. We have to see in this whole power equation which power can we take. Because no one is going to hand you power on a platter, whether

you are a man, woman, relationship, rich, poor, political, young, old. The power needs to be taken. And once we recognize that, then you realize you have actually more power than you thought you did. It's just that you never realized that you do have that power. Now linked to that, that's why I said be the change that you want to see. It's not easy, but it's not impossible. So I need to speak out. It's not easy, but unless you do, no one is going to do for you. And so it's the same, whether you are on your career, you are in an institution. I know that there's always that little voice that always tells you this is not right. It's always there. And so you have to figure out how do I open my mouth and let that little voice come out? And as I've said, you will be surprised sometimes how easy it is when you open your mouth. Once you've encountered injustice and you think that this is not right, you will be surprised. Even the person you thought would react and be dangerous, they are disarmed by the truth and the courage to speak the truth. So for me, that's what I would say. We have to be the change that we want to see, if we see injustice and we don't like injustice, we need to speak out. But other than speaking out, we need to find what are the things that we can do to dismantle this injustice? And then the next, recognize that no one is ever going to give you power and find ways to take it.

Garry Aslanyan [00:36:36] Great. Agnes, your parting thought.

Agnes Binagwaho [00:36:40] So to add on that, because that's true, we should not sit and wait to the world to be good for us. The world has shown us that during 400 years. I think we need also to educate ourselves. To understand how a power dynamic in systems are created. To understand what equity means really and to understand that it's our duty to fight for equity and inclusiveness. And this power imbalance between the Western world and Africa, we'll need to work on that to change it, as much as we need to work in our country for a better life for the vulnerable. And we need to ensure that the research, the education we give, works in that sense and to gather evidence for better advocacy. And, as Catherine said, we need to talk. And we need to learn how to do efficient advocacy: educate, advocate, take responsibility and also show the example of what you do in your own community for equity and inclusiveness.

Garry Aslanyan [00:38:03] Thanks so much, Catherine and Agnes. This was really a very candid and thought-provoking discussion. You both raised so many valuable points. Thanks for this. So what I took out of this is that first, there is a real need to look critically at the knowledge management system, the biases it creates and how it may skew health programming. Second, what I heard is that research systems need to be strengthened in a way that low- and middle-income countries have the capacity to take the lead on larger projects. Then what I heard that respectful relationships are vital in research partnerships. And of course, lastly, now more than ever, low- and middle-income country researchers need to be active participants in a movement towards greater equity and inclusiveness.

Garry Aslanyan [00:39:00] As we come to the end of the first season of the Global Health Matters podcast, we also want to thank you, our audience. I'm so pleased that you've joined us for so many episodes, we had 10 in season one, and we hope that we gave you an opportunity to look at various topics in global health from a very different angle. We're very grateful to all of our guests who joined us in season one and actively participated. Coming up in March, we will be chatting to some of our listeners to hear their feedback on season one. Please don't miss that episode. We're excited to announce that season two will be starting in April this year. We will kick off the new season with discussions on topics such as access to medicines and diagnostics, science diplomacy, migration and health, the role of artificial intelligence in global health, and many others. Until next time, I'm your host, Garry Aslanyan. Join us again, take care and stay healthy.

Elisabetta Dessi [00:40:13] Global Health Matters is produced by TDR, the Special Programme for Research and Training in Tropical Diseases. Garry Aslanyan, Lindi van Niekerk and Maki Kitamura are the content producers and Obadiah George is the technical producer. This podcast was also made possible with the support of Chris Coze, Elisabetta Dessi and Izabela Suder-Dayao. The goal of Global Health Matters is to provide a forum for sharing perspectives on key issues affecting global health research. Send us your comments and suggestions to tdrpod@who.int and be sure to download and subscribe wherever you get your podcasts. Thank you for listening.