Can schools of global public health dismantle colonial legacies?
By Ngozi A Erondu, Dorothy Peprah and Mishal S Khan

The United Kingdom's leading global public health university, London School of Hygiene and Tropical Medicine (LSHTM) recently issued an unprecedented statement to its staff and students about the urgent need to address racial inequalities at the institution, The statement, acknowledged the school's 'roots in colonial history and an ideology' that has 'created institutional structures which continue to reinforce racism and bias'. It comes after LSHTM and other global public health universities across the United Kingdom have been rocked by calls for an acknowledgment of, and actions to address, colonial structures which continue to perpetuate racial inequalities inside and outside of the organization. At LSHTM, for example, a letter signed by us and over 600 other students, alumni and staff details very personal, and sometimes painful, accounts of systemic racism, harassment and discrimination. The letter echoed sentiments in similar calls for action by leading global health organizations like Médecins Sans Frontières (MSF).

The transfer of energy from the US to Europe to stand against racist practices has been palpable. Protests on both continents are requiring re-examination of historical underpinnings of modern-day structural racism in various institutions. This same is true of academia where European Universities confront colonial legacies. Even as current problems of racism at UK Universities are highlighted in the Equality and Human Rights Commission Report (https://www.equalityhumanrights.com/en/inquiries-and-investigations/racial-harassment-higher-education-our-inquiry) , the historical underpinnings of structural racism as an extension of colonialism and white-centric paradigms are rarely acknowledged nor fully addressed. LSHTM has a mission to 'improve health worldwide'. However, along with other insitutions, it was founded to strengthen the dominance of the British Empire. At its 1909 opening, the school's founder, Patrick Manson exhorted British Imperialism and lamented that "The Africa problem, like the Asian one before it, was *the white man's burden".*

More than 100 years later, on July 2nd , the institution's Decolonizing Global Health (DGH) group and the Black Lives Matter (BLM) network, were invited to address the LSHTM Council—the school's governing body—to explain how its unexamined colonial history continues to manifest in the universities' policies and practices.

Colonial legacies and neocolonialism—defined by some academics as the practice of reinforcing colonialist practices of control and influence through, mostly unconscious actions, behaviors, attitudes, and beliefs— are a systemic operating model that is shapes career opportunities, research partnerships, and teaching practices (1).

Careers: As a recent study, led by one of us (and shunned by many universities for highlighting their lack of progress in diversity and inclusion) showed, the faculty composition at the top fifteen universities teaching public health, all based in the UK, America or Canada- is clearly white at the top and BAME at the bottom (2). This begs the question - are BAME students and

staff there to learn and do the ‘fieldwork’, but not considered skilled enough to make it through the promotion systems?

Research: Our experiences at LSHTM included constant negotiation to resolve the disconnect between the expressed needs of “local staff” , research participants and the decisions of London-based senior and supervising researchers. This included advocating for fair and timely payment, realistic workplans (e.g. reflective of the local environment), and due credit for contribution through authorship. Even the research ethics review board sometimes failed to consider cultural context and preserved European standards and assumptions to African study sites and collaborating institutions. Racial hierarchy and cultural hegemony in research is not unique to LSHTM; for over a century global health research imbalances and white-centrism has narrowed the interpretation of scientific discovery and stolen recognition from many Global South researchers. Dr Yap Boum, an epidemiologist with MSF, has written that the lack of investment in African scientists has led to Western researchers leading African-based research (3). Seye Ambimbola, Editor of BMJ Global health, made prominent the concept of the ‘foregin gaze’ and asserts that the dominance of science in lower income countries through the narrative, assumptions, and perspectives of scientists from high income countries, corrupts certain realities and disconnects important research findings from the local audience it should serve (4).

Teaching: Writing about our own experiences of structural discrimination at LSHTM and global public health writ large has invited the experiences of students at global public health universities. Many shared how a white-centric colonial curriculum over-generalizes and diminishesthe “global south” and additionally, how some lecturers use demeaning language to describe local populations. Further, the lack of representation at universities leads to reduced mentorship for BAME students and dismissal of their issues. In some instances, this has led students to withdraw from their course.

It is indeed telling that there are very few examples of UK institutions that have moved past anti-racism statements to dismantling structural racism. Unique is Kings College London, which has spent years not only embedding equality, diversity, and inclusion into its institutional infrastructure but has also set up a transparent monitoring process for accountability to its community. But more must follow. An academic institution that inadequately addresses the modern-day inequities of its past risks its future. At LSHTM, DGH and BLM reflect a new generation of global public health professionals that are entering in the field and are more empowered to question unexamined assumptions, legacies and the so-called heroes of the industry. And they are rightly demanding more of their institutions.

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Acknowledgements
The authors acknowledge the London School of Hygiene and Tropical Medicine's Decolonize Global Health group and the Black Lives Matter network of current and former staff and students.

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Contributions
NAE, DP, and MSK conceived the idea together. NAE developed the first draft; MSK and DP made significant revisions to the draft; and all authors approved the final version for publication.

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Competing interests
The authors declare no competing interests.