The words we choose matter: recognising the importance of language in decolonising global health

Recognition of the relevance of colonial history to the contemporary practice of global health is not new, but the recent increase in visibility and prominence given to it by global health institutions and flagship journals is welcome when accompanied by meaningful reflection and action.[1]

The goal of decolonising global health is to critically reflect on its history, identify hierarchies and culturally Eurocentric conceptions, and overcome the global inequities that such structures perpetuate.[2] We must reflect on the terminology we use when we discuss global health challenges, phrase research questions, write papers, teach students, or interact with patients, research participants, and the public. Although our choice of words shapes an audience's understanding of global health, the restricted range of expressions and terms prevents us from offering more nuanced and appropriate perspectives. The conceptualisation of English terms in other languages is often limited to literal translation that struggles to reproduce the same meaning, as highlighted by recently emerging technical terms, such as social distancing. Thus, to make real progress in the process of decolonising global health in our minds and practices, awareness, reflection, and change of language are fundamental.

Most global health literature is still published in English only. This Anglocentrism narrows engagement with many international readers and poses a barrier to authorship for researchers whose working language is not English, which reinforces the power dynamics of the field.[3] By contrast, it is neither generally required nor practiced for foreign researchers working in low-income and middle-income countries to learn the language(s) of the country or region they are working in. This tendency, plus the absence of mechanisms to connect research networks operating in parallel in different languages, means that an English-speaking academic has little incentive and restricted capability to engage with scientific advances being published in Mandarin, Spanish, French, Arabic, and other widely spoken languages. Finding ways to bridge these language barriers in research and bibliographic databases is a fundamental pathway to knowledge co-production and equal research partnerships.

Global health comes burdened with the weight of history and uses a range of terms rooted in contexts of historical domination, dependence, and subordination.[4] Tropical medicine is a problematic term that slips between its geographical delineation and its imperial heritage, even as its use persists, including in the names of prestigious institutions. This historical burden is reproduced in other artificial and othering dichotomies such as Global North versus Global South, high-income versus low-income and middle-income countries, and resource-rich versus resource-poor settings, which reduce countries with different histories, cultures, and practices into a single identity, and consequently influence policy discussion. Nuanced understandings about alternative terms, and their interpretation and application in multiple contemporary social contexts, are needed to ensure we are equipped to describe complex and highly specific realities. Although there is WHO guidance on naming new infectious diseases, many terminological categories in the field require widespread and inclusive critical discussion of their origins and usage.[5] These include diseases named after their colonial discoverers (eg, *Trypanosoma brucei rhodesiense*), a country or region where the disease is or was endemic (eg, Guinea worm), a geographical area or landmark where a disease has been discovered (even inaccurately, such as Ebola virus[6]), and colonial territorial attributions (eg, New World or Old World leishmaniasis). Thus, there remains a lot of work to overcome the colonial legacy of language in global health. Even with contemporary challenges, such as antimicrobial resistance and COVID-19, controversial terms that can stigmatise regions have entered scientific and public discourse.[7,8] Although China, the UK, South Africa, and Brazil are widely recognised as places where SARS-CoV-2 and important variants were first identified, the associated stigmatisation has not been equally felt, and has been most marked towards east Asian communities worldwide.[8]

The list of global health terms that have historical and political problematic connotations is long. Although there have been in-depth debates about examples in subspecialty fields, a discipline-wide approach is lacking.

Similarly, few resources offer definitions and reflection on use, expand defined thematic areas, or critically discuss etymology.[9] Collaborative approaches are required to enable development and shared ownership of such resources among the global health community. The good practice of providing multilingual abstracts as a first step should be more widely adopted by authors and journals.[3]

Analogous to what Seye Abimbola[10] stated about authorship, language "per se is not the fundamental issue; undoing what those imbalances represent—a continuity of the colonial project in global health—is often the issue." Jointly reflecting and changing the terms we use in global health when we talk, write, teach, and study is far from enough, but it is an essential part of the process of disrupting the power dynamics sustained through colonial continuity.

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1 Hirsch LA. Is it possible to decolonise global health institutions? *Lancet* 2021; **397:** 189–90.
2 Affun-Adegbulu C, Adegbulu O. Decolonising global (public) health: from western universalism to global pluriversalities. *BMJ Glob Health* 2020; **5:** e002947.
3 Pakenham-Walsh N. Improving the availability of health research in languages other than English. *Lancet Glob Health* 2018; **6:** e1282.
4 Erondu NA, Peprah D, Khan MS. Can schools of global public health dismantle colonial legacies? *Nat Med* 2020; **26:** 1504–05.
5 WHO. World Health Organization best practices for the naming of new human infectious diseases. May 15, 2015. https://www.who.int/publications/i/item/WHO-HSE-FOS-15.1 (accessed March 15, 2021).
6 Piot P, Marshall R. No time to lose: a life in pursuit of deadly viruses. New York: WW Norton and Company, 2012.
7 Rolain JM, Parola P, Cornaglia G. New Delhi metallo-beta-lactamase (NDM-1): towards a new pandemia? *Clin Microbiol Infect* 2010; **16:** 1699–701.
8 McNall Ay. What makes new variants of SARS-CoV-2 concerning is not where they come from, but the mutations they contain. Feb 16, 2021. https://blogs.bmj.com/bmj/2021/02/16/what-makes-new-variants-of-sars-cov-2-concerning-is-not-where-they-come-from-but-the-mutations-they-contain/ (accessed March 15, 2021).
9 Verga D. How we talk about public health and why it matters. Nov 11, 2020. https://www.path.org/articles/how-we-talk-about-public-health-and-why-it-matters/ (accessed March 15, 2021).
10 Abimbola S. The foreign gaze: authorship in academic global health. *BMJ Glob Health* 2019; **4:** e002068.