

# Global health is more than just 'Public Health Somewhere Else'

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## INTRODUCTION

King and Koski<sup>1</sup> recently published a bold commentary in *BMJ Global Health* that defines global health as 'public health somewhere else'. It raises important concerns about the justification, scope, efficiency and accountability of the field. We appreciate that the commentary compels us to reflect on the definition of global health, its application and how the field could be improved. We also agree that many of the issues highlighted by the authors (ie, political priorities driven by the North, expertise from the North being overvalued) do exist in some global health interventions. Many of us have heard of or witnessed disastrous situations caused by seemingly well-intentioned people. However, the problems described are not unavoidable or intrinsic characteristics of global health. Moreover, we believe the proposed definition of global health is not adequate to conceptualise the field. Rather than prompting improvements, it could result in mistrust towards global health and be a step backwards for the field. In the following, we contend that global health is more than just 'public health somewhere else' and argue that an inadequate definition entails risks for the field.

## GLOBAL HEALTH IS MORE THAN JUST 'PUBLIC HEALTH SOMEWHERE ELSE'

First, we argue that King and Koski's<sup>1</sup> definition is not adequate, because global health is not always 'somewhere else'. According to Koplan *et al*,<sup>2</sup> the term global refers to the scope of problems, not their location. In fact, we believe that global health can be anywhere. This field of research and practice often addresses problems that are rooted in transnational determinants or 'supraterritorial' links<sup>3</sup> (eg, war, climate change, natural disasters, colonisation, international trade, forced migration, international policies) and that have negative effects on national and

## Summary box

- ▶ Global health can be anywhere as it often focuses on large-scale health inequities that are rooted in transnational determinants.
- ▶ Some global health initiatives and actors aim to find solutions to domestic problems.
- ▶ King and Koski's definition of global health may exacerbate inequities by reserving the right to call oneself a global health researcher to those who are privileged and have access to funding that enables them to travel to other settings.
- ▶ An inadequate definition of global health based on a 'here' vs 'somewhere else' dichotomy could result in less funding for a field already characterised by limited resources.
- ▶ The decolonisation of global health requires promoting and valuing reflexivity, critical approaches, equitable partnerships and accountability.

local determinants of health (eg, employment conditions, access to healthcare, income differentials). The populations of interest in these instances can be anywhere (low, middle and high-income countries) and include anyone affected and facing health inequities due to these transnational or global issues. The solutions can also be global or transnational in nature.

The coronavirus pandemic is an example of a global health problem that is affecting people *everywhere*, especially vulnerable groups. Due to the ever-increasing movement of people across borders, viruses like covid-19 can spread easily and quickly around the world and affect anyone, irrespective of whether they are in the global North or South. A global health response involving most countries that includes data sharing and coordinated efforts to stop the spread, find treatments and a cure as well as protect vulnerable groups (eg, elderly, migrants, prisoners, homeless) is therefore necessary.

Second, we disagree with King and Koski's<sup>1</sup> statement that 'a person engages in global health

when they practice public health somewhere—a community, a political entity, a geographical space—that they do NOT call home'. To us, this is an oversimplified statement. Several of our colleagues, and we as well, have received funding to engage in global health in places we call home. For example, KK has conducted research on social protection policies in Burkina Faso, her home country. Similarly, NA has conducted research on the health of migrant workers in Bangladesh, where he lives. We should be applauding and valuing global health initiatives that are led by local researchers/practitioners rather than excluding them from the definition.

Moreover, King and Koski's<sup>1</sup> definition is not adequate because some global health initiatives are aimed at finding solutions to domestic problems, whether it be in a high, middle or low-income country. For example, Grand Challenge Canada funded the adaptation and transfer of innovations from low and middle-income countries to make a difference in Canada. While the innovations come from abroad, the primary focus or end goal of such initiatives is quite local. This also highlights the fact that solutions for health problems in the North and South sometimes stem from expertise in the South.<sup>4 5</sup> According to Syed *et al*,<sup>4</sup> global health partners are increasingly seeking a mutuality of benefits across countries.

Third, there are many public health researchers and practitioners working 'somewhere else', in a place that 'they do NOT call home', whose work does not qualify as global health. They do not view themselves as part of the global health community, nor do they actively participate in global health activities. Their practice and research would also not be eligible for global health funding. For example, a Canadian medical student's clinical placement in a public health unit in Belgium is not automatically considered training in global health simply because it is done in another country. Therefore, referring to global health merely as public health 'somewhere else' is not useful.

Fourth, we consider that King and Koski's<sup>1</sup> commentary and definition discredit the field of global health and fail to recognise its added value. While it is crucial to reflect on limitations, it is also important to highlight the field's strengths, best practices and success stories.<sup>6 7</sup> There are examples of global health research and interventions where countries and communities have worked collaboratively and shared expertise, cultural knowledge and other resources to develop appropriate and effective solutions.<sup>8-10</sup>

Moreover, while global health is considered one of the multiple branches of public health, the literature does suggest there are differences among them.<sup>11</sup> For example, global health tends to have a broader focus (ie, health for all worldwide), a greater emphasis on health inequities, more interdisciplinarity<sup>2</sup> and more 'bridging' between cultures and communities. Practitioners and researchers working in global health also face unique ethical challenges (eg, power differentials between parties) and require that some key competencies be

further developed (eg, cultural safety and inclusion, partnership development).<sup>6 11 12</sup>

Recognising global health as a field in its own right is crucial to ensure there are dedicated resources for training and forums where the global health community can exchange and share knowledge, so that best practices can be further promoted, especially among students and emerging researchers and practitioners. It is also vital that global health be recognised as a distinct field so that resources will be made available to support global health initiatives that can promote the human right to health and help meet the global pledge to 'leave no one behind'.

### THE RISKS OF USING AN INADEQUATE DEFINITION

The proposed definition by King and Koski<sup>1</sup> entails several risks. First, accepting the definition proposed would mean that global health initiatives led by local actors or community leaders in low or middle-income countries, or by indigenous or migrant communities in high-income countries, would not be acknowledged and considered global health. This in turn could lead to devaluing their contribution as global health actors and limiting their access to resources to support their work, despite there being significant needs. Therefore, rather than moving us 'towards an eventual decolonisation of global health', the definition by King and Koski<sup>1</sup> might actually reinforce the problems they highlight in their article, including inefficiency, lack of accountability and uncritical faith in Western expertise, because only 'foreigners' would be acknowledged as doing global health.

Second, the definition may exacerbate inequities by reserving the right to call oneself a global health researcher, and the related expertise, exclusively to those who are privileged and have access to funding that allows them to travel and practise or conduct research in other settings that they do not call home. Third, the definition would limit the scope of problems and solutions considered, possibly neglecting global and transnational issues. Fourth, if global health is conceptualised as public health elsewhere, what interest would countries and communities have in investing in global health? This could result in less funding for a field that already faces the challenge of limited resources.

Lastly, the definition and commentary imply that working somewhere else is somewhat problematic and negative. We are concerned that this view is divisive and dangerous. It could contribute to ethnocentrism and ultimately limit the sharing of knowledge and expertise across groups. A 'here' versus 'somewhere else' dichotomy seems counterproductive. We live in a globalised world, and more than ever we are interconnected and interdependent. Everyone in high, middle and low-income settings has a vested interest in attaining health for all and reducing health inequities. Concerns over pandemics (covid-19!), global warming, environmental degradation

and potential misuse of technological advances (the easy spread of fake news!) affect us all. Protecting the most vulnerable is beneficial for everyone—for our economic, social, mental and physical well-being. As a Burkinabé saying goes, ‘we are together’.

## CONCLUSION

Currently, global health may not be perfectly practised, but we need inclusive definitions, frameworks and training programmes that set the standards towards which we should all strive. We can have transparent discussions and be critical of global health academic programmes, research and practices, while sharing an adequate definition. We should condemn bad practices, rather than condemn the whole field. True partnerships across disciplines and geographic boundaries, which have resulted in meaningful projects, exist and can be further promoted.<sup>9 13</sup> We need to promote the strengths and best practices of the field and value success stories while learning from failures.

Ultimately, the decolonisation of global health requires training programmes that teach reflexivity, critical approaches, equitable partnerships and accountability. Such training programmes, and all global health initiatives more broadly, should include participatory approaches and ensure there are benefits for all stakeholders involved. Resources should also be expended equitably. These are all good practices that are attainable. This is the morally ‘right way’ to do global health, and also a more effective way to achieve ‘health for all’.

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