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Using antioppressive teaching principles to transform a graduate global health course at Johns Hopkins University

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ABSTRACT

Education systems and pedagogical practices in global public health are facing substantive calls for change during the current and ongoing 'decolonising global health' movement. Incorporating antioppressive principles into learning communities is one promising approach to decolonising global health education. We sought to transform a four-credit graduate-level global health course at the Johns Hopkins Bloomberg School of Public Health using antioppressive principles. One member of the teaching team attended a year-long training designed to support changes in pedagogical philosophy, syllabus development, course design, course implementation, assignments, grading, and student engagement. We incorporated regular student self-reflections designed to capture student experiences and elicit constant feedback to inform real-time changes responsive to student needs. Our efforts at remediating the emerging limitations of one course in graduate global health education provide an example of overhauling graduate education to remain relevant in a rapidly changing global order.

SUMMARY BOX

⇒ Global health education faces ongoing calls to decolonize its curriculum and pedagogical approaches.
⇒ There is little clarity on how best to achieve this goal but one promising approach to decolonizing global health education is by incorporating anti-oppressive principles (AOPs) into teaching.
⇒ AOPs were used to transform a graduate-level global health course at Johns Hopkins University by informing the teaching team's pedagogical philosophy, specific course activities, assessments, grading approaches, and responsiveness to regular student feedback.
⇒ By engaging in anti-oppression, there is a potential to reconceptualize and transform how we educate about and practice global health.

INTRODUCTION

Global health education faces ongoing calls to decolonise its curriculum and pedagogical approaches. This is not surprising given how education systems and structures in global health uphold pervasive power asymmetries that favour white, Euro/Global North-centric voices and experiences in curriculum, competencies and pedagogy.[1 2] Education movements focused on decolonisation recommend that programmes re-examine teaching and education practices[3] through undoing, unlearning, redoing, and relearning to 'create societies free from the remains of the colonial era in their culture, education, and institutions'.[4] A recent literature review on decolonising curriculum and pedagogy suggests that decolonising education can mean (1) recognising constraints, (2) disrupting, and (3) making room for alternatives.[5]

Antioppressive teaching and learning principles

One promising approach to decolonising global health education is by incorporating antioppressive principles (AOPs) into teaching. Antioppression can be understood both as a process and an outcome. As a process, antioppression refers to the eradication of oppression through awareness and institutional/structural change. The application of AOPs requires an awareness that society is based on unequal distribution of power and privilege because of an intentional divide that is maintained between the privileged and the disadvantaged.[6] Building on this awareness, the intended outcome is to achieve systemic and structural change to create systems that are oriented towards social justice; a relational orientation to the humanity and dignity of all people.[7]

To prepare students to critique and challenge systems of oppression and reorient them towards social justice, faculty must be prepared to 'actively work to dismantle the structures, policies, institutions, and systems that create barriers and perpetuate race-based inequities for people of color…'.[8] However, research into teaching practices in US schools of public health that declare social justice as part of their mission has shown that

AOPs have had limited reach within public health pedagogy to date.[6] Rather, the focus has tended to be on the conceptually more limited notions of equality, equity, and diversity which do not seek systems change but instead focus on increasing individual awareness of differences without giving us tools to change the systems that sustain inequities among us. Even in situations when equity and diversity-related topics emerge in the classroom, faculty tend to avoid these conversations because they feel ill-equipped and hope to evade negative feedback from their students.[6]

While diversity, equity, and inclusion (DEI) focused conversations about individual differences and awareness of social identities are important, they are usually devoid of a critical analysis of power, history and sociopolitics.[9] Antioppression, however, specifically requires the consideration of context, history and power for individuals to critique and change the systems within which we operate. The oppression that is present in US higher education spaces comes as a result of settler colonisation, characterised by power and domination of one group over another. More specifically, according to Sharon Stein 'it is through processes of settler colonialism that many of us are here today, and all U.S. colleges and universities were built on dispossessed Indigenous lands'. Stein also notes that extending an invitation into an existing 'settler colonial state' does not achieve the goal of decolonisation, especially since institutions as systems require faculty, students, and administrators to reproduce colonisation to be deemed successful.[10]

To affect change it is important to commit to an orientation towards justice, even when particular interventions may be imperfect. In fact, there is no perfect moment to engage in this work.[10] There are no perfect interventions since true decolonisation would require a complete dismantling and rebuilding of current systems. It will require the use of transformative tools created by Indigenous, grassroots, and majority world communities, centreing the '…voices of the poorest, darkest-skinned, more disabled, women (cis and trans), and femmes' in decision and policymaking.[9]

We sought to use AOPs for teaching and learning to transform a graduate-level global health course at the Johns Hopkins Bloomberg School of Public Health (BSPH) and explored a possible connection between antioppression as a tool towards decolonising global health education. This manuscript describes the process of engagement in AOPs and their underlying guiding principles.

A note on decolonisation

We acknowledge that the concept of decolonisation has gained immense traction in the last 20 years, so much so that there are now calls to decolonise the decolonisation movement.[9] The concept itself has two main roots—one that comes from Indigenous peoples who are still battling effects of settler colonialism and one that comes from those who gained independence in the 20th century but still experience political and economic effects of colonisation. As a result, the act of decolonisation differs based on the context. While, decolonisation, at its core, rests on undoing the effects of colonialism, for the purpose of this paper, we focus on the experiences of the Global South and, specifically, the calls to how education and pedagogy can be decolonised.

Johns Hopkins University

Johns Hopkins University, founded in 1876, is a private research university located in Baltimore, MD, US. The university is named for its first benefactor, a quaker who was hailed as a fervent abolitionist until a 2020 review of census records revealed his ownership of at least five enslaved people in the 1840s and 1850s. At the time of its establishment, the Johns Hopkins Medical Institutions (JHMI) occupied approximately 14 acres of land and has since expanded to more than 140 acres in East Baltimore. This expansion is a direct result of the same kind of settler colonisation on which the US is built. JHMI's relations with the East Baltimore community have been fraught and the university remains an ivory tower in a majority African American city.[11]

Federal and state-funded programmes continue to target the same neighbourhoods created by Jim Crow and redlining policies. JHMI has capitalised on the resulting hypersegregated spaces and concentrated poverty by supporting private and uneven neighbourhood development. This further undermines functional community networks, destroys neighbourhood organisations, businesses, cultural institutions, and the political power and social capital of Black Baltimore residents. Much like enslavers hired patrollers to protect their human capital investments (ie, enslaved people), JHU is moving ahead with plans to create their own police force, in direct opposition to the wishes of the people who live within their fiefdom. 'Ironically, it could be argued that this institution known around the world for curing diseases has in its past and current expansions contributed negatively to its own neighbours' health outcomes through urban renewal tactics and serial forced displacement over the past century'.[12]

Cultivating Anti-Oppressive Learning Communities Training

In 2021, the Cultivating Anti-Oppressive Learning Communities (CAOLC, www.caolc.org) programme was launched at BSPH. The objective of CAOLC is to support teaching faculty at BSPH to redesign their curricula to incorporate AOPs in teaching and reorient their pedagogy towards justice. Interested faculty were invited to apply to join the cohort; the CAOLC team selected participants based on their expressed interest and availability. In addition to the CAOLC training, each participant received a stipend ($1000 USD) which could be used to support their teaching activities or professional development.

CAOLC uses the five principles of antioppression as a tool to guide faculty to build awareness in themselves and

their students to affect systemic change. The courses are not designed to support systematic change themselves but to equip students with skills to start a journey towards systematic change.

Participants of CAOLC are trained to see and name the oppressive practices that are grounded in white supremacy culture. They develop skills to orient away from and disrupt oppressive practices and create alternate impacts in their teaching and, by extension, to prepare their students to do the same in their future public health practice.

The five principles of antioppression are:

- Engage in critical consciousness.
- Be aware of geographical, historical and present context.
- Power relations differ and should be analysed according to context.
- Social differences influence power relations.
- The personal and political are linked and people are influenced by larger social structures and systems.

Application of AOPs can take the form of teaching students to engage in critical self-reflection, identifying and discussing power dynamics that impact classroom dynamics, and can translate into public health practices, intentionally creating equitable and mindful classrooms and grounding course content within historical, political, and present contexts, so that students can see how systems of oppression influence public health practice.[6]

Over the course of 18 months, CAOLC implemented a peer-advising model during which participants reflected on their teaching and practiced intentional ways of reorientation towards incorporating AOPs. The key technology for this process is the participant Pedagogy and Curricular Work Plan worksheet, which serves as a document of accountability (to individual participants and their peer group) and reflexivity. Over several peer-to-peer meetings, participants develop a pedagogical philosophy, a stance on teaching and SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals for shifting their curriculum and pedagogy towards antioppression.

We applied learnings from the CAOLC training to a foundational graduate-level course, 'Global Disease Control Programs and Policies (GDCPP)' within the BSPH Department of International Health (DIH). We seek to describe the process and immediate outcomes to inform similar global or international health graduate programmes and further improvement on the BSPH/DIH core curriculum.

ORIGINAL COURSE APPROACH AND IMPETUS FOR CHANGE

GDCPP was launched over 10 years ago as a culminating graduate course for master's and doctoral students in the BSPH DIH. This four-credit course was designed to leverage experts in the field (and at the University) to discuss major disease control programmes and policies and introduce key analytic skills. While this course underwent many minor changes over the years, the basic approach remained the same: the class met two times a week for 110 minutes, guest lecture experts would present for roughly 70 minutes on specific large disease areas (ie, Tuberculosis, HIV/AIDS, Non-communicable diseases, maternal and child health, etc), and students would participate in short, related exercises (ie, debates, elevator pitches, discussion, etc).

While the course was broadly viewed as successful and received strong (but not excellent) reviews, key motivators for substantive change emerged over time. First, student reviews consistently identified the following issues:

- A lack of non-Western perspectives (both in terms of speakers and content).
- Repetitive material from courses taken in earlier terms.
- Insufficient time for activities and skills-building.
- Unclear linkages between didactic materials and skills-building sessions.

It also became clear to teaching faculty, through the review of final assignments, and departmental comprehensive exams, that while students may be meeting the established competencies, they were not grasping critically important themes (ie., those related to decolonization).

The CAOLC training then became the ultimate catalyst, leveraging these existing motivators and offering new skills and approaches that could be used to affect meaningful change.

REVISED COURSE APPROACH

The CAOLC programme called on participants to redesign their syllabi and consider new approaches to pedagogy and course implementation. While only one of the GDCPP lead instructors was enrolled in the training, the lessons learnt were shared with the entire teaching team which included a coinstructor and three graduate-level teaching assistants (two doctoral students and one master's student).

Together, the teaching team identified five themes to address throughout the course. These themes did not define a single session but were recurring and reinforced through various learning approaches (ie., readings, videos, discussions, etc). Students were alerted to these themes on the first day of class:

- Role of colonialism on the nature of global health programmes/policies today.
- How priorities are established and are drivers of change.
- Tensions between programmes along the horizontal—vertical spectrum.
- Shared strategies and challenges across global health programmes.
- The complex intersection of stakeholder interests.

The teaching team also defined and shared their pedagogical philosophy which was designed to foster an inclusive environment to facilitate discussion on complex,

sometimes divisive topics, and catalyse skill building. This approach deeply incorporated AOPs:

- We recognise the racist and colonial underpinnings of many global health programmes and policies, including the ones we discuss in this course.
- We aim to use different avenues to amplify the voices of underserved and oppressed communities (ie., through panels, readings, videos and other course materials).
- We recognise students as cocurators of knowledge; student experiences and perspectives are valued in this course.
- We aim to call-in, not call-out. We ask students to do the same with us, and with each other.

Course schedule and activities

The course was redesigned with this approach in mind. Guest speakers were replaced by panels designed around a specific theme that featured diverse voices, inclusive of those in low and middle-income countries (LMICs). Readings were carefully curated to ensure a representation of women authors and authors from LMICs. Specific time was dedicated each week for students to reflect on the readings in class. They were asked to identify a peer and discuss the reading using the probes: 'What did you learn?', 'What surprised you?' and 'What did you disagree with?' These probes were intentionally selected to promote critical thinking and learning while providing opportunities for students to synthesise readings with peers. Panels were accompanied by skill-building workshops where students practiced a specific skill in small groups. Table 1 provides an overview of the course schedule over the 8-week term.

Table 1 Course calendar and activities

Week	Session 1	Session 2
1	Course overview	Global priority setting
2	Panel 1: Horizontal and integrated programmes	Workshop 1: Strenghts, Weaknesses, Opportunities, Threats (SWOT) analysis
3	Panel 2: Vertical programming	Workshop 2: SWOT analysis (again)
4	Panel 3: Health campaigns	Workshop 3: Stakeholder analysis
5	Panel 4: Non-communicable diseases/ role of industry	Workshop 4: Fishbowl discussion
6	Panel 5: Built environment	Workshop 5: Haddon matrix
7	Analysis of policy making (short lecture+short workshop)	Knowledge translation (short lecture+short workshop)
8	What works in global health/what's next—lecture+group work	Group presentations

Assessments

Most assessments were related to each workshop and submitted by groups. This would generally include the specific product developed in the workshop accompanied by annotated notes. Students were also asked to submit short self-reflections following most workshops to self-assess their own performance. Self-reflections asked students to describe their preparation, engagement, follow-up, and extent to which they understood the concepts and/or still had outstanding questions. Students were also asked for feedback on the workshop itself, so we could gather information throughout the course, and not just during the standard final evaluation.

Due dates—windows of opportunity

The teaching team also reflected on challenges related to assessment due dates, particularly when they were tied to regular workshops. Anecdotally, faculty experience a common challenge with last minute requests for extensions and providing on-time feedback. We then defined due dates as 'windows of opportunity for feedback'. Students could turn in assessments at any time during the term but would only receive feedback if they submitted assessments by the due date, or at the discretion of the teaching team.

Ungrading

The CAOLC training also introduced a concept known as 'ungrading', which seeks to promote students as the experts of their own learning.[13 14] We aimed to deemphasise grades and instead focus on improved engagement over time, facilitated through thoughtful comments and ongoing conversations. While students submitted many group and individual assessments, the teaching team provided detailed feedback in lieu of grades. Each assessment submitted within the window of opportunity for feedback received robust comments. Most self-reflections also received feedback to encourage and reflexively identify change over time. Our detailed processes and procedures for implementing ungrading are reported elsewhere.[15]

Remaining nimble to embrace change

As described in the antioppressive approach we used, we also sought to decentre instructor expertise by recognising everyone as a cocurator of knowledge. In addition to recognising students' lived experiences as critical to deepening everyone's understanding of the course content, we also relied heavily on their experience in the course itself.

One important feature of this course redesign was the use of self-reflections to capture regular feedback. This was our first time initiating these changes, and our designs, while inclusive of teaching assistants' input, were not always student centred. Regular feedback, combined with regular team meetings, allowed the team to meaningfully respond to student concerns. Examples are included in table 2.

Table 2 Workshop design, ongoing modifications and associated outcomes

Design feature	Initial configuration	Modified configuration	Outcomes
Group size	Large groups, approximately eight people	Smaller groups, approximately four people.	More manageable for deliverables; increased individual participation
Group stability	Stable groups, rarely changing members	Regularly changing	Increased networking and exposure to classmates
Workshop location	One larger lecture hall with all teaching team members	Two breakout rooms with divided teaching team	Easier to hear each other; allowed more time for presentations and feedback
Approach	Largely online and using computers (ie, jam board, shared folders)	Introduced physical posters and sticky notes to encourage movement	Increased dynamic engagement; Online systems often created logistic challenges

Teaching team reflections

Members of the teaching team, including faculty and student teaching assistants, reflected that incorporating these changes transformed their own relationship with students, moving from hierarchical and adversarial to collaborative and engaging. We found that by removing such structures as deadlines and grades, we were able to more deeply engage with students on curriculum-specific issues, exploring material and expanding learning opportunities. Course reviews were excellent (both quantitative scores and the tone and tenor of qualitative feedback), representing a major and positive shift from previous years.

DISCUSSION

While this manuscript describes the transformation of a single course, its effects have already reverberated across the DIH. Other teaching faculty are beginning to explore and implement ungrading and embracing regular student feedback. We encourage these changes with both enthusiasm and caution. Without training, resources, and reflection, the implementation of new or unfamiliar models, like ungrading, can have unintended consequences. For example, Beckie Supiano notes that 'professors must guard against inadvertently holding students to unspoken standards (which can be) particularly harmful for disadvantaged students who come to college less familiar with the 'hidden' curriculum' that orients insiders'.[16]

Affecting change in teaching and learning is a process, not a single revision of a course. While we asked students to self-reflect in this course, faculty must also regularly reflect on their pedagogy and its implementation, but most graduate instructors and professors are not trained educators. That is, they have expertise in their scientific areas but not expertise in teaching and pedagogy,[13] and can feel ill-equipped to change the way they teach.[16] This can result in faculty reinforcing existing hierarchies through hidden curricula, power dynamics that privilege written histories over oral histories and lived experiences, and further marginalising communities of students who are not insiders (eg, first generation, English as a second language, etc). Only by cocreating, critically self-reflecting, and intentionally engaging with content can faculty begin to reorient towards a practice of justice.

We also recognise that institutes of higher learning are not designed to support many of these changes. Faculty in Schools of Public Health tend to rely on soft funding, needing research grants to support their effort. Rarely do they have substantive protected time from their Universities to devote to training, course redesign and teaching[17–19]; the organisational reward systems do not align with the needs of the institution and its members. The teaching team member who participated in CAOLC was not financially supported to do so (beyond the CAOLC stipend) but was already drawn towards a community that would help affect course changes. And while fellow CAOLC participants and members of the teaching team were largely supportive, some changes were met with resistance. For example, DIH administrators were concerned that 'ungrading' approaches would fail to meet Council on Education for Public Health competency assessment requirements. Furthermore, remaining nimble in response to ongoing student feedback requires a strange mix of preparation and flexibility. Workshops were well planned in advance, but we had to make space to incorporate substantive changes with limited time for implementation. Our team was dedicated to this approach, but it was sometimes draining amidst competing priorities.

Many faculty also benefit from the very systems we have described. For faculty to reach their current positions, the system must have worked for them, or they were able to work the system to their favour. This may make these same faculty resistant to pedagogical changes. The perpetuation of what some have termed the 'feudal structure of global health' has far-reaching implications for framing the ways in which global health or public health professionals are trained.[20] We are cognisant that educating graduate students in global health is linked to the way in which the larger global health world is structured. This makes it a larger challenge to dismantle existing hierarchies of power and incorporate justice and AOPs as the basis of curricular evolution.

The call to decolonise courses, institutions, and global health as a whole, is an aspiration. Unless we choose to

divest entirely of the structures on which our current systems are built, there is no way for us to completely decolonise. Furthermore, as Audre Lorde reminds us, 'the master's tools will never dismantle the master's house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change…'.[21] Even with appropriate support and the best of intentions, decolonisation in its fullest sense is not possible within the limits of our current systems; but we must still try if we are to make progress towards a more just and equitable world for all people.

CONCLUSION

Global health education has played a role in upholding the status quo of the power asymmetry against the global majority. By engaging in antioppression, there is a potential to reconceptualise and transform how we educate about and practice global health. Our efforts at remediating the emerging limitations of one course in graduate global health education provide an example of overhauling graduate education to remain relevant in a rapidly changing global order. We encourage faculty and administrators at institutes of higher learning to consider how AOPs can be used to reshape global health education systems, structures, classrooms and pedagogies.

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