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Educational approaches to teach students to address colonialism in global health: a scoping review

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ABSTRACT

Introduction The enduring legacy of colonisation on global health education, research and practice is receiving increased attention and has led to calls for the 'decolonisation of global health'. There is little evidence on effective educational approaches to teach students to critically examine and dismantle structures that perpetuate colonial legacies and neocolonialist control that influence in global health.

Methods We conducted a scoping review of the published literature to provide a synthesis of guidelines for, and evaluations of educational approaches focused on anticolonial education in global health. We searched five databases using terms generated to capture three concepts, 'global health', 'education' and 'colonialism'. Pairs of study team members conducted each step of the review, following Preferred Reporting Items for Systematic reviews and Meta-Analyse guidelines; any conflicts were resolved by a third reviewer.

Results This search retrieved 1153 unique references; 28 articles were included in the final analysis. The articles centred North American students; their training, their evaluations of educational experiences, their individual awareness and their experiential learning. Few references discussed pedagogical approaches or education theory in guidelines and descriptions of educational approaches. There was limited emphasis on alternative ways of knowing, prioritisation of partners' experiences, and affecting systemic change.

Conclusion Explicit incorporation of anticolonial curricula in global health education, informed by antioppressive pedagogy and meaningful collaboration with Indigenous and low-income and middle-income country partners, is needed in both classroom and global health learning experiences.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Global health education programmes play a role in perpetuating global inequities by reinforcing Eurocentric standpoints and centring European systems of knowledge.

WHAT THIS STUDY ADDS

⇒ While the field of global health is facing ongoing calls to 'decolonise' most content ends at the individual-level (ie, self-awareness and critical reflection) and little has been published on how to embed anticolonial principles into curricula, pedagogical practices and education systems.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ There is a need for continued exploration and publication within academic global health to build an anticolonial curriculum in the field.

BACKGROUND

The meaningful incorporation of anticolonial principles into global health education is critical to efforts to decolonise global health.[1–4] This movement is rooted in the work of historically and currently colonised peoples, with voices and leadership from Indigenous communities and low-income and middle-income countries (LMICs) central to the discussion.[5] The topic of decolonising global health is not new,[6] but recent discourse has been motivated by a series of more recent publications and related student movements.[7]

Discussions on how to decolonise global health have focused on building equitable local and Global North–South partnerships and research.[3 4 8–10] Practically, this can mean substantial changes in how we practice global health including—but certainly not limited to—community or country-driven prioritisation of issues, more equitable geographical distribution of resources and bidirectional flows of human resources. Kwete *et al* identify three colonial remnants in global health, including practices that further strengthen unequal power hierarchies; organisations and regulations that put more power in the powerful and unwritten norms that the developing world is incapable of solving its own health problems.[9] Similarly, Olusanya *et al* comment on serious problems with philanthropy and aid models that channel money to support countries in the Global South without involving institutions in those countries. They say, 'when decisions about

African lives are taken solely in the Global North, this conveys and fosters white supremacy'.[11] Several authors from LMICs and other marginalised communities have written about the process of decolonisation within health research; from conceptualisation[3] to grant agreements, administration and accountability[12] to the importance of non-tokenistic representation of collaborators from LMICs in publications, editorial leadership, grants and project leadership.[13–15]

The role of global health education programmes and institutions in perpetuating inequities and colonial ideologies has been similarly explored. Many have criticised global health education for reinforcing Eurocentric standpoints and ways of seeing the world.[3 16] This is, in part, due to the colonial origins of the field of global health. Early international health organisations stemmed from colonial health authorities. Their programmes were situated within colonial settings and their employees frequently transitioned between international health organisations and colonial health authorities, blurring distinctions between the two.[17] They centred the health and economic well-being of the colonists and employed colonial rule to force health interventions on the colonised, regardless of the negative impacts.[18] This 'way of working' fed into the creation of international health education programmes established by these same organisations and remains inherent in the more recently defined field of global health education.[9 17]

Presently, medical education in colonised countries, past and present, is a colonial institution that gives power to European systems of knowledge and erases other ways of knowing.[16 19] Naidu and Abimbola describe this as a standardisation of European epistemology which inherently devalues or eradicates other epistemologies.[16] This prioritisation of European systems is evident within the current global health educational system at a systems level. In their editorial, 'Global health degrees: at what cost?' Svadzian *et al* show that there is a disconnect between where global health training is needed and where degree programmes are currently offered.[20] That is, most global health programmes are based in high-income countries (HICs) and serve HIC students. Tuition, in conjunction with living and travel costs, make these programmes inaccessible to students from LMICs. Short-term experiences in global health (STEGHs), where students from HICs travel to LMICs to conduct research or practice, are a staple in many global health programmes. STEGHs have been widely critiqued as a one-directional flow of knowledge, benefiting students far more than their hosts.[21] This disconnect is also evident among Indigenous communities in settler colonies. American Indian and Alaska Native (AI/AN) individuals are under-represented in both percentage of applicants and matriculants to US medical schools despite significant health inequities and the importance of appropriate care.[22 23]

Efforts to incorporate anticolonial principles into global health education can operate at multiple levels to detect and disrupt the remnants of colonialism that impact health.[1] First, curricula and pedagogy play a critical role in the validation and/or marginalisation of people and systems of thinking[24] and therefore must be reimagined through an anticolonial paradigm to decolonise global health. Second, education provides a mechanism for anticolonialist praxis through critical self-reflection, cocreated curricula, bidirectional learning and equitable partnerships. Third, anticolonial education has the potential to mobilise global health practitioners and researchers who acknowledge the role of colonialism in perpetuating systems of inequity and actively pursue ways to recreate them. Other academic disciplines such as education, anthropology, sociology and women's studies have been grappling with the operationalisation of anticolonial education and yet there is still no consensus.[25] In these fields, anticolonial education has included the visible aspects of what we teach (curricula) and how we teach (pedagogy)[26] as well as the hidden curriculum and epistemologies.[27] As part of the Johns Hopkins Bloomberg School of Public Health's (BSPH) Inclusivity, Diversity, Anti-Racism and Equity (IDARE) Initiative, we conducted a scoping review to understand the current landscape of educational approaches addressing colonialism in global health and to develop recommendations for moving these efforts forward.

When presenting incorporation of anticolonial principles into global health education as critical to the decolonising global health movement, it is important to note that truly decolonising global health will only be actualised through dismantling colonial institutions and decolonising the world's political economy.[9] Prominent discourse includes Lorde's commentary titled, 'The Master's Tools Will Never Dismantle the Master's House',[28] and Tuck and Yang's definition of decolonisation as the 'repatriation of land and life'.[29] This article, however, attempts to explore efforts within the current field of global health education to disrupt 'the colonial mindset that (has) subconsciously made us less sensitive to the colonial remnant in daily practices and in the organizational setup'.[9]

METHODS

Definitions

The term 'decolonise' is used throughout the background given its consistency with the current dialogue around this topic. We acknowledge that there are significant gaps in the use of the term, including its potential use as a metaphor rather than instigator of change,[29] its disregard for associated violence[12 30] and a lack of attention on the underlying white supremacy ideology.[31]

We conceptualised anticolonial education as a set of approaches that can contribute to the decolonising global health movement. We defined anticolonialism in global health education as training practices focused on dismantling colonial legacies and neocolonialist control and influence in global health and across majority world health systems. Neocolonialist control resulted in and

continues to maintain hierarchies in global health career opportunities, research partnerships, teaching practices, care practices and funding opportunities. Hierarchies are structured in ways that privilege Western actors and systems (of knowledge, health and social organisation) relative to those of the majority world.

Anticolonial education in global health offers approaches that take an active stance to address wide ranging structural issues that include (but are not limited to): colonialism/neocolonialism, cultural hegemony, global health ethics and bioethics (focused on systems and structures), global health engagement, structural violence, structural or systemic racism, structural inequalities, structural competency, systems of power and privilege in global health, white supremacy, white saviorism.

For the purposes of this scoping review, we did not expand our definition to include 'Indigenous health'. This is an essential component of anticolonial education in global health and should be an explicit focus of future research.

Search strategy

We conducted an initial search of five databases in May 2021: ERIC, PubMed, CINAHL, Web of Science and Embase. An updated search was conducted in February 2022 to capture recently published articles. Search terms were related to 'global health', 'education' and 'colonialism'. Search terms are provided in online supplemental material. There were no date, language or study design restrictions applied.

Study selection

Pairs of reviewers (HN and SP or GB) independently screened titles and abstracts for study eligibility. Full-text review was then conducted by the same three reviewers. At each stage, conflicts were discussed as a group and resolved by consensus or by adjudication by a fourth reviewer (AK). Studies were included if they focused on delivery of actual or recommended curricular content, course objectives, learning competencies, guidelines, educational approaches and/or teaching strategies on topics related to anticolonialism in global health for public health and health professions trainees. All screening was conducted in Covidence.

Data extraction and analysis

Data were extracted using standardised forms in Covidence by pairs of reviewers (HN, SP or GB). One reviewer (HN) checked for accuracy and completeness and resolved discrepancies. Data on context, study design, teaching and learning delivery mode, content, institutions involved and author recommendations were extracted for each reference. References were split into two categories: (1) guidelines and recommendations; (2) descriptions and evaluations of educational approaches. Extracted data from each reference were exported to an Excel sheet for analysis. Two authors (HN and SP) analysed the data using the framework method.[32]

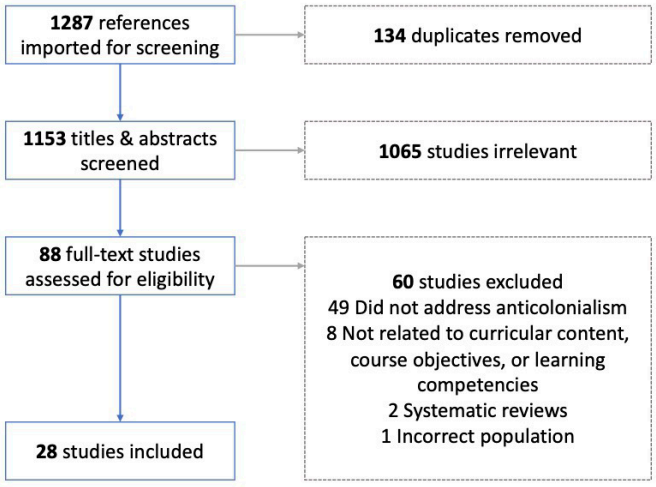

Figure 1 PRISMA diagram. PRISMA, Preferred Reporting Items for Systematic reviews and Meta-Analyses.

Patient and public involvement

Members of the public were not involved in the design or conduct, or reporting or dissemination plans of our research.

RESULTS

The search identified 1287 references which were imported into Endnote and deduplicated. After removing 134 duplicates, 1153 references underwent title and abstract screening; 1065 references did not meet the inclusion criteria. We conducted full-text review on 88 references and excluded 60 for not relating to our definition of anticolonialism in global health education (n=49), not describing curricular content, course objectives, or competencies (n=8), being a systematic review (n=2) and not covering our target population(s) (n=1). Figure 1 depicts this process in a Preferred Reporting Items for Systematic reviews and Meta-Analyses diagram.

Characteristics of included references

Twenty-eight articles were included for analysis. Articles were published between 2010 and 2021. Only six of the 28 references included at least one author affiliated with an LMIC institution.[33–38] Every article included involved an institution(s) based in a HIC. Sixteen references were written with the purpose of proposing guidelines or recommendations related to anticolonial public health (see Table 1 for a breakdown of topic areas).[33–36 39–50] Sixteen articles described or evaluated educational approaches.[37 38 45 48–60] Reference target audiences were health professions institutions or students (n=22), global public health institutions or students (n=15) and healthcare providers (n=3). The problems and solutions related to decolonising global health as articulated by study authors are summarised in Table 2 and explored further throughout the results.

Table 1 Topic areas covered by study authors recommending anticolonial educational approaches to health (n=16)

Author year	Competencies	Curricula	Predeparture course	Global health experience
Adams *et al* 2016[33]	x			
Beavis *et al* 2015[39]		x		
Cole *et al* 2011[40]	x			
Crump *et al* 2010[34]				x
Eichbaum 2017[41]	x			
Eichbaum *et al* 2021[35]	x	x		
Finnegan *et al* 2017[42]		x		
Garba *et al* 2021[43]		x	x	x
Harvey *et al* 2020[36]	x			
Holden and Satcher 2016[50]	x			
Lattanzi and Pechak 2011[44]			x	x
Lokugamage *et al* 2020[45]		x		
McKinnon *et al* 2016[49]	x	x		
Racine and Perron 2012[46]			x	
Shah *et al* 2019[47]			x	x
Ventres and Wilson 2020[48]				x

Curriculum development

Competencies, learning theory and pedagogy and paradigms and principles are components of curriculum development within global health education. Competencies articulate the desired outcomes of education, learning theory and pedagogy provide the theoretical basis for teaching methods and student activities or assessments, and paradigms or principles inform the creation of course curricula and content. Conceptualisation of education at this stage impacts all other areas that follow—content, teaching and learning delivery, and educational environment—whether it is made explicit or not.

Competencies

Seven references recommended the adoption of learning competencies related to anticolonial education for students of global health.[33 35 36 40 41 49 50] One reference explicitly referred to decolonising global health.[35] All included references incorporated competencies that addressed developing an understanding of the history of colonialism[33 41] or systems of power, privilege and inequality[33 35 36 40 41 49 50] in global health. Competencies that involved higher-level learning focused mainly on critiquing systems of power and privilege in global health.[35 49] Competencies related to building equitable partnerships included skills to involve host communities and institutions as leaders in decision-making[49] and shared learning via bidirectional exchange and reciprocity among students and institutions.[40 49] Cole *et al* developed sets of competencies for global health research and practice. These competencies focused on developing knowledge of global health systems and structures, community engagement and effective communication and collaboration.[40]

Learning theory and pedagogy

Only two references explicitly discussed the use of learning theory or pedagogy to inform teaching approaches or curriculum development.[41 55] Eichbaum (2017) described the need for transformative learning approaches to address colonialism within global health education. They classified competencies as 'acquired' or 'participatory' to encourage critical reflection on the importance of social context and interactions in certain competencies.[41] This classification also allows for reflection on delivery and assessment, particularly for participatory competencies which may benefit from collectivism and 'self-directed assessment seeking', and addresses cultural hegemony by prioritising alternative models such as sharing.[41] Neff *et al* was informed by critical pedagogy and collaboratively developed a structural competency curriculum, calling attention to structural violence and the 'naturalisation of inequality'. The curriculum explores the structural inequalities and systems of power that influence health with a focus on praxis via application of the structural competency framework to clinical interactions.[55]

Paradigms and principles

A small proportion of references (n=4) reflected on the paradigms and principles used to inform curriculum development.[35 44 46 51] In their 2021 article, Eichbaum *et al* recommended developing global health curricula using common public health principles such as patient safety and interdisciplinary principles, including fair

Table 2 Problems and solutions related to decolonising global health as articulated by study authors

Author year	Problem	Solutions
Adams *et al* 2016[33]	Inequitable partnerships in global health education and practice which can replicate past colonial relationships.	Guidelines for ethical engagement with partners.
Beavis *et al* 2015[39]	Without proper training, global health practitioners, researchers, students and learning institutions can be agents of colonialism.	Provide training in postcolonialism; engage in postcolonial practices.
Citrin *et al* 2017[38]	Inequitable partnerships in global health education and practice which can replicate past colonial relationships.	Create more equitable partnerships with LMIC partners by promoting two-way dialogue and confronting power dynamics.
Cole *et al* 2011[40]	None directly related to decolonising global health. Educational problem: lack of clearly articulated competencies in global health.	None directly related to decolonising global health. Educational solution: develop clearly defined global health competencies.
Crump *et al* 2010[34]	Inequitable and unethical partnerships in global health education and practice which can replicate past colonial relationships.	Guidelines for ethical engagement with partners.
Eichbaum 2017[41]	Without proper training, global health practitioners, researchers, students and learning institutions can be agents of colonialism.	Use global health-specific competencies for learner assessment which have been developed in partnership with LMIC partners; provide training in cultural context (eg, collectivism).
Eichbaum *et al* 2021[35]	Inequitable partnerships in global health education and practice which can replicate past colonial relationships.	Create more equitable partnerships with LMIC partners through critical reflection and concomitant action.
Evert 2015[51]	Inequitable partnerships in global health education and practice which can replicate past colonial relationships.	Create more equitable partnerships with LMIC partners through asset-based educational programmes.
Ferrel *et al* 2020[52]	None related to global health. Educational problem: poor understanding among residents of the barriers that patients who live in the Bronx face.	Global health training in social medicine which includes critical race theory, structural competency and intersectionality.
Finnegan *et al* 2017[42]	Imposition of colonial hierarchies in global partnerships, student demographics and poor understanding of social factors in LMICs which create health disparities (social medicine).	Training in social medicine focused on praxis, critical self-awareness and equitable partnerships.
Garba *et al* 2021[43]	Global health training strategies reinforce colonial power differentials and disproportionately benefit HIC institutions.	Appropriate training for learners, equitable partnerships and institutional changes.
Harvey *et al* 2020[36]	Poor understanding of harmful social structures, some of which arose from colonialism, perpetuates social and health inequities.	Training in structural inequities/structural competency; system-levels interventions.
Holden and Satcher 2016[50]	Global health inequity.	Training to promote health equity and guidelines for global health initiatives.
Hutchins *et al* 2014[53]	International immersion programmes do not develop cultural competencies in and of themselves (ie, inadequate training provided in global service-learning programmes).	Culturally immersive learning experiences which incorporate principles of 'cultural competency 2.0'.
Jacobsen *et al* 2021[60]	None directly related to decolonising global health. Educational problem: lack of clearly articulated global health 'field of graduate study and practice'.	None directly related to decolonising global health. Educational solution: examine global health concentrations.
Lattanzi and Pechak 2011[44]	Inequitable partnerships in global health education and practice can be harmful to LMIC partners and communities.	Ethical engagement with LMIC partners.
Lokugamage *et al* 2020[45]	Colonised ideas of healing result in poor patient care and health inequities.	Proper training of HCPs to meet the needs of diverse populations.

Continued

Table 2 Continued

Author year	Problem	Solutions
McKinnon *et al* 2016[49]	Inadequate training provided in global service-learning programmes.	Creation of a framework for global service-learning programmes which promotes community-driven learning experiences and critically reflective practice.
Myers and Fredrick 2017[54]	The structure of global health learning experiences perpetuates global power hierarchies and may not provide adequate training to students.	Ethical engagement with LMIC partners (longitudinal involvement, student investment/commitment).
Neff *et al* 2020[55]	HCPs are not adequately trained to respond to the effects of social, political and economic structures.	Training HCPs to respond to the effects of social, political, economic structures (eg, colonialism) to provide better patient care.
Rabin *et al* 2021[37]	Inequitable partnerships in global health education which can replicate past colonial relationships.	Equitable institutional partnerships and representative leadership.
Racine and Perron 2012[46]	HCPs not adequately trained to address the effects of colonialism in 'cross-cultural placements'.	Training HCPs to respond to the effects of colonialism to provide better patient care, through cultural safety and 'decolonising the mind'.
Sbaiti *et al* 2021[59]	The structure of global health education perpetuates global power hierarchies and may not provide adequate training to students.	Codesign curricula with individuals with 'lived experience'.
Shah *et al* 2019[47]	Inequitable and unethical partnerships in global health education and practice which can replicate past colonial relationships.	Equitable and ethical engagement with LMIC partners.
Ventres and Wilson 2020[48]	Inequitable and unethical partnerships in global health education and practice which can replicate past colonial relationships and negatively impact learning and professional development.	Proper training will lead to better provision of care and more equitable partnerships.
Willott *et al* 2019[56]	Inequitable and unethical partnerships in global health education and practice which focus more on the learner than the impact on the community can replicate past colonial relationships.	More equitable engagement with partners; more structured electives.
Wu *et al* 2021[58]	Structure of global health learning experiences perpetuates global power hierarchies and is inherently inequitable.	'Consider alternative ways to teach international skills' such as virtual engagement.
Zaidi *et al* 2017[57]	Lack of cross-cultural dialogue in culturally diverse classrooms leads to cultural hegemony.	Training facilitators to promote cross-cultural dialogue will be a counter to cultural hegemony.

HCP, healthcare providers; LMIC, low-income and middle-income countries.

trade and approaches to address power dynamics in development narratives (ie, Asset-Based Community Development approach to community-based development; see Figure 2).[35] Other references described global health curricula that was developed and implemented with the ethical principles of beneficence and non-maleficence.[44 51] Racine and Perron suggested educating nursing students to employ a postcolonial feminist paradigm and Bakhtin's dialogism when serving patients in international settings.[46] In the article, the authors suggest that postcolonial feminist epistemology can be applied to understand patients' intersectionality, historical and sociopolitical environments, and the importance of praxis. This epistemology informs a practical approach via Bakhtin's dialogism, or dialogue and unfinalisability, which acknowledges the individuality of dialogue and cautions against generalising an individuals' dialogue to a group.[46] This approach would facilitate anticolonial education in global health by challenging cultural hegemony and promoting cultural safety, which is determined by patients and is an environment where they feel safe and power imbalances are actively challenged.[61 62]

Content

Curriculum development leads to content, which includes curricula, subjects of study, course and lesson objectives, theories, tools, applied skills and course activities. These findings illustrate the information provided to students within classes related to anticolonial global health education.

Curricula and course content

Sixteen references specifically addressed curricula and course content related to anticolonial education in

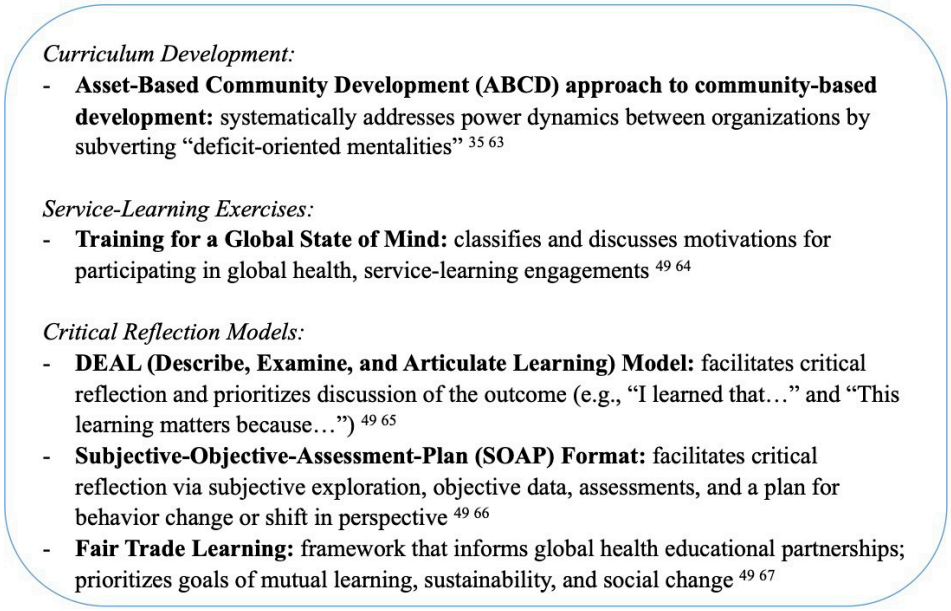

Figure 2 Selected resources for curriculum development and course content.

global health.[35 37 39 42 43 45 49 51–59] References described conceptual course content on the history of colonialism in global health,[39 43] structural humility as related to structural competency[55] and social justice, as related to systems of power and privilege in global health.[42 51 52] Ferrel *et al* specifically discussed exploring illness through a lens of power and oppression and stimulating informed action in medicine, contributing to social justice, antiracism, racial equity, activism, advocacy and allyship in the medical field.[52] Seven references discussed cultural sensitivity,[37 39 43 45 49 51 58] with variations in vocabulary including cultural safety,[39 45] cultural competency,[45 51 58] cultural humility[37 45] and intercultural sensitivity.[49] Five of these references did not elaborate on the meaning of these terms[37 43 51] or provided definitions that did not meet our definition of anticolonial education.[49 58] Two references discussed cultural safety as related to postcolonial theory and the ability to reflect on context, power and privilege prior to a client interaction.[39 45] One reference defined cultural humility as a tool to disrupt unconscious biases and power imbalances that are a result of colonial influences in global health.[45]

Ten articles described applied skills which were deemed important for improving global health, including development of cross-cultural skills (particularly in dialogue and clinical care),[56 57] different ways of knowing or meaningfully considering other perspectives[35 39 43 45 49 58] and social medicine.[42 52] Lokugamage *et al* presented medical pluralism (which includes various ways of knowing and practicing medicine and was eliminated by the European 'medical power hierarchy') and Indigenous knowledge as alternative ways of knowing that challenge predominant biomedical ways of knowing and may serve to disrupt power imbalances and colonial legacies in medical education.[45] McKinnon *et al* provided specific examples of content via service-learning exercises and critical reflection models that allow students to explore and question systems of power and privilege in global health, white saviorism, neocolonialism via global health educational partnerships and cultural hegemony (Figure 2).[49 63–67]

Teaching and learning delivery

Teaching and learning delivery address how content is delivered and evaluated versus what is delivered (ie, content). Included articles explored teaching delivery via experiential learning and didactic learning and learner assessment and evaluation. Critical self-reflection was raised as one approach to learning delivery within anticolonial global health education.

Experiential learning

Ten references provided recommendations[34 43 47 49] or evaluations[42 51 53 54 56 58] for global health experiences, mainly targeting medical students (n=6).[43 47 49 53 54 56] Almost all (n=9) of the included articles discussed experiential learning through students' engagement with an LMIC host-country.[34 42 43 47 49 51 53 54 56] Finnegan *et al* discussed an approach to global health engagements guided by the three P's: praxis, personal and partnership which could be employed to address power dynamics in global health engagements and relationships between HIC-educational and LMIC-educational institutions.[42] This approach centres reflection accompanied by action, critical self-awareness and reciprocal engagement with partner organisations. The three P's were operationalised in 3 to 4week engagements in Uganda, Haiti and the USA, with half the students from the country where the course is taught.[42] One reference evaluated an educational programme involving students' long-term and repeated engagement with LMIC host-institutions over the course of a 4 year undergraduate medical programme.[54] Wu *et al* described an alternative approach

to global health experiences altogether. Learning was conducted via an experiential learning approach during the COVID-19 pandemic which sought to teach 'intercultural competencies' through online peer engagement.[58] Sbaiti *et al* also presented an alternative approach that combined experiential learning and didactic learning via involvement of individuals with direct interaction with course content (ie, lived experience).[59]

Didactic learning

None of the included references described coursework solely focused on anticolonial global health. However, several references recommended building anticolonial knowledge and skills in global health which was delivered in a classroom setting.[35 43 44 47 52–56] More than half of these references (n=5) focused on predeparture coursework, short courses conducted prior to a global health cross-cultural placement.[43 44 47 53 56] Of these, four references described site-specific predeparture courses which they argued would better prepare students for global health cross-cultural experiences by centring cross-cultural clinical care (eg, accommodating different belief models),[56] navigating 'cultural misalignments',[44] developing successful partnerships with LMIC host-institutions[43] and learning history and politics as a way to highlight power and inequality.[53]

The remaining four references described and evaluated classroom-based courses related to anticolonial global health education. Neff *et al* outlined an approach to developing a course on structural competency for medical trainees and interprofessional teams. The course is delivered in three 1 hour modules (two facilitator-led and one discussion-based).[55] Another reference described a month-long Social Medicine 'immersion' rotation for medical residents involving lectures, panel discussions, workshops and reflection sessions.[52]

Learner assessment and evaluation

Few references explicitly discussed strategies for learner assessment and evaluation. Most references focused on the assessment of educational approaches to examine the benefit for individual learners and did not describe potential benefits, if any, to Indigenous partners, LMIC partners, global health departments or other stakeholders.[42 51–53 55–59] Additional details about the educational approaches and the results of evaluations are outlined in Table 3.

Critical self-reflection

Three references advocated for the incorporation of critical self-reflection into learning delivery via critical consciousness,[57] critical self-awareness[42] and critically reflective practice (see Figure 2 for examples of critically reflective practice in course content).[49] Critical consciousness and critical self-awareness can be incorporated into learning through introspection and awareness of systems of power and privilege as personal realities.[42 57]

Educational environment

The educational environment can be described as the institution or system where education takes place, such as a university or community organisation and their partners and collaborators. The structural issues embedded in our definition of anticolonialism in global health education highlight the influence of the educational environment on curriculum development, content and teaching and learning delivery.

Only two references described institutional-level considerations influencing global health education,[43 47] which could impact efforts towards anticolonial education. Garba *et al* suggested recruitment of faculty committed to developing equitable collaborations with global health partners and requiring faculty to involve partner organisations at all stages of research. The authors also recommended development of institutional task forces which would be responsible for ensuring that students and faculty prioritise health equity in all global health activities.[43] Shah *et al* presented individual-level, program-level and societal-level recommendations, arguing that incentives and disincentives are needed at multiple levels to reform the current landscape of global health engagements.[47] Specifically, individuals can consider alternatives to achieve the same personal outcomes or reorient their expectations to align with the expressed desires of the community; programmes can shift focus to sustainable, community-defined outcomes and implement communications campaigns about 'responsible' engagement and society can implement policies aimed at more rigorous admissions protocol and comprehensive monitoring and evaluation.[47]

LMIC partnerships

Many references discussed the importance of developing equitable education partnerships with LMIC partners, but only ten described how to build these partnerships.[33 35 37 38 40 43 44 47 51 56] Specific recommendations for equitable engagement with LMIC partners included ensuring defined roles, contracts, coordination and strong communication with partners,[37 40 43 44 56] attention to strategic planning,[43 44 47] alternative funding structures (eg, funding of host country institutions),[37 38 43 56] bidirectional exchange,[33 35 37 38 43 51 56] prioritisation of host country goals[37 38 44 47 51] and close oversight to prevent students from practicing outside their level of training.[35 38 43 56]

Sbaiti *et al* specifically advocated for the involvement of LMIC partners in curriculum development.[59] They detailed the cocreation and codelivery of global health curricula at Imperial College London involving LMIC partners. They described a model that incorporates educators, research and data experts, student partners and alumni and individuals with lived and professional experience in the topic area to take part in curriculum design.[59] Citrin *et al* evaluated a global health academic partnership through the lens of the Tropical Health and Education Trust (THET) Principles of Partnership framework.[68] This evaluation positions the THET framework as an approach to quality assurance and evaluation within partnerships.[38]

Table 3 Results of evaluations on anticolonial educational approaches to global health (n=10)

Author year	Educational approach	Description	Institutions involved	Results of evaluation
Evert 2015[51]	Global health experience	**Child Family Health International (CHFI) Global Health Education Programmes** **Principles of learning**: non-maleficence, respect for persons, cultural humility and social justice. **Delivery**: 2 to 16 week global health education programmes for individual students and university partners predominantly from the Global North. CHFI places learners in clinical, public health and NGO settings in LMICs. **Interaction with host community and partners:** Offers social entrepreneurship opportunities (hosts to create and administer educational programmes), honoraria for local preceptors, compensation for homestay families, remuneration of community members for programme coordination and leadership and opportunities for professional development and CHPs. Claims to use an Asset-Based Community Development approach.	Child Family Health International	▶ Increased prestige for local health professionals when framed as experts and an increase in global connectedness for lay and professional community members[83] ▶ Participants report a broadened sense of determinants of health and increased appreciation for the cultural influences on health and healthcare[84]
Ferrel *et al* 2020[52]	Curriculum or course	**Social Medicine Immersion Month; Residency Programme in Social Medicine at Montefiore** **Topics**: 1. Forms of systematic family separation including immigration, mass incarceration, mandated reporting 2. Antiracism and racial equity within public health and medicine 3. **Global health partnerships and imperialism** 4. Labour movements in healthcare 5. Activism, advocacy and allyship in medicine **Delivery:** 27, 1 to 2 hour sessions delivered over 3 weeks (lectures, panel discussions, workshops, reflection sessions, optional after-hours off-site activities). Facilitators who were engaged in the community were sought out.	Residency Programme in Social Medicine at Montefiore	▶ Participants reported that sessions facilitated needed conversations regarding physicians' power within healthcare delivery to minoritised and oppressed populations ▶ Participants reported changes in their perception of power dynamics in healthcare within marginalised populations, and greater awareness of issues of segregation, critiques of health systems and community self-determination
Finnegan *et al* 2017[42]	Global health experience	**SocMed and Equal Health Social Medicine Course** **Topics (from website http://www.equalhealth.org/socialmedicine-2021, not article):** Part 1—Social Determinants of Health: Accounting for Local and Global Contexts Part 2—Health Interventions: paradigms of Charity, Development and Social Justice Part 3—Core Issues in Social Medicine: Primary Healthcare, Community Health Workers, Health and Human Rights and Health Financing Part 4—Making Social Medicine Visible: Writing, Narrative Medicine, Deep Listening, Photography and Community Organising and Leadership **Delivery:** 3 to 4 week courses in Uganda, Haiti and the USA for medical, nursing and other health professions students from host country and other countries. Instruction through community visits, film, group work, theatre of the oppressed and small-group and large-group discussion. Teaching philosophy focused on facilitating the cocreation of knowledge with participants, developing critical self-awareness and developing equitable partnerships.	SocMed and EqualHealth	Participants identified the following challenges: ▶ Lack of diversity among course directors ▶ Course content developed by North Americans ▶ Socioeconomic and educational inequities among students ▶ Sense of demoralisation and discouragement reported by students following course Lessons Learnt: ▶ Build equitable partnerships ▶ Embrace discomfort ▶ Link reflection with action through praxis ▶ Build an intentional community

Continued

Table 3 Continued

Author year	Educational approach	Description	Institutions involved	Results of evaluation
Hutchins *et al* 2014[53]	Global health experience	**University of Wisconsin–Madison Global Health Institute Field School for the Study of Language, Culture and Community Health Pilot Programme** **Preparatory course curriculum:** Spanish language, region-specific topics, community engagement principles **In-country curriculum:** Language classes; anthropology seminars informed by medical anthropology, medical geography and applied anthropology (study, discussion, field observations and community visits); CBPR-informed community engagement activities and service-learning projects supervised by UW faculty and collaborating HCPs (eg, distributing antiparasitic medications, leading health workshops). **Delivery**: Semester long preparatory course involving didactic lectures. Spring orientation with course director; 5 week placement in Ecuador (students placed with homestays).	University of Wisconsin–Madison Field School for the Study of Language, Culture and Community Health.	Lessons Learnt: ▶ Building trusted networks in the university and host country and continuity in community partner relationships is fundamental for safe, sustainable, quality global health experiences. ▶ Interdisciplinary expertise, community engagement and critical reflection facilitates learning
Neff *et al* 2020[55]	Curriculum or course	**Structural Competency Curriculum for Medical Students, Residents and Interprofessional Teams** **Learning objectives:** 1. Identify the influences of structures on patient health. 2. Identify the influences of structures on the clinical encounter. 3. Generate strategies to respond to the influences of structures in the clinic. 4. Generate strategies to respond to the influences of structures beyond the clinic. 5. Describe structural humility as an approach to apply in and beyond the clinic. **Delivery:** 3, 1 hour modules led by a facilitator in a classroom environment. Modules 1 and 2: cases, discussion, arrow diagrams, didactics with definitions of terms to provide trainees with shared frameworks and vocabulary. Module 3: Examples of responses to harmful social structures, brainstorming exercise designed to inspire action at various scales among participants. All modules: 'Reflective segments to encourage trainees to apply the learning to their own experience thus far and to their intentions moving forward'.	University of California San Francisco	▶ Participants valued the focus on application of the structural competency framework in real-world clinical, community and policy contexts. ▶ Participants with clinical experience (residents, fellows and faculty) reported that the training helped them reframe how they think about patients (away from blaming and other possible misconceptions). ▶ Participants reported feeling reconnected to their original motivations for entering the health professions.
Sbaiti 2021[59]	Curriculum or course	**Virtual Roundtable for Collaborative Education Design (ViRCoED) model of curriculum design** **Process:** Educators elect stakeholders/partners to work with. Educators conduct roundtables with workgroups and define team objectives (and operations limits). **Goals of programme:** 'Model attempts towards reflexivity and better inclusivity in their own work, thus contributing to students' meta-learning'.	Imperial College London	▶ Informal process evaluation completed by students, external examiners and partners. ▶ Increased self-reflexivity was observed in student assignments.

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Table 3 Continued

Author year	Educational approach	Description	Institutions involved	Results of evaluation
Willott *et al* 2019[56]	Predeparture course; global health experience	**Dundee online preparation modules for global health electives (required for all students)** **Topics:** Module 1: Planning your elective (aims; factors influencing destination and specialty choices; concept of medical tourism; attitude; potential language, cultural and ethical issues) Module 2: Knowing your environment (introduces global health issues) Module 3: Thinking about risk (explores risks under seven themes: communication, personal health, clinical risks, accommodation, travel and leisure, people and culture and regional factors) Module 4: Elective ethics (using case examples explores the impact of language barriers; working within competency; impact of limited resources; decision-making in different cultures and consent) **Goals of programme:** 'Optimise student learning, including developing a strong sense of global citizenship and promoting a more considered and fairer "trade" in electives, where host sites benefit'. **Delivery:** 6 week elective in the fifth year of undergraduate medical education focused on longitudinal engagement with existing partner sites. Students fundraise for the benefit of the host. **Interaction with host community and partners:** MOU developed with host sites.	University of Dundee, UK LMIC partners in Zambia and Malawi	Programme outcomes: ▶ Improved communication with host institutions ▶ Students reported an improved educational experience when compared with similar electives
Willott *et al* 2019[56]	Global health experience	**Ben-Gurion University of the Negev, Beer-sheva, Israel Medical School for International Health (MSIH)** **Predeparture orientation** **Curriculum**: Health, safety, cross-cultural clinical care, 2 day intensive simulation programme with actors. **Delivery:** Predeparture orientation in third year. **Global health experience** **Curriculum:** Not reported. **Delivery**: 8 week global health experience for capstone experience in fourth year of undergraduate medical education; required for all students. **Relationship with partners:** Students from host countries receive scholarships to do clinical rotations at MSIH for 12 weeks. LMIC partners compensated for costs associated with student placement.	Medical School for International Health, Israel (MSIH) LMIC partners in Ghana, Ethiopia, India (three sites), Nepal, Sri Lanka, Mexico and Peru	▶ No systematic evaluation of the programme ▶ Feedback from debriefing sessions universally positive
Wu 2021[58]	Curriculum or course	**Short-term structured international online programming** **Learning objectives:** 1. Cultural competency 2. 'Networking, leadership, collaboration skills' 3. Global literacy **Delivery:** 8 week online programme with international peer networking and exchanges. Weekly small group and large group online meetings; sessions facilitated by student leaders.	Columbia University, King's College London, Kyoto University, Ludwig Maximilians University, Martin Luther University, McGill University, Medical University of Vienna, National Taiwan University, Tokyo Women's Medical University, University of Cambridge, University of Copenhagen, University of Paris	▶ Based on a prestudent and post student self-assessment of cultural competencies, the 'majority of students felt that their level of intercultural awareness had improved'

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Table 3 Continued

Author year	Educational approach	Description	Institutions involved	Results of evaluation
Zaidi *et al* 2017[57]	Instructional approach	**Online educator discussion** **Topics:** Training to introduce and handle sensitive cultural topics, particularly if educators were to facilitate such discussions, including when and how to pose clarifying questions to deepen the dialogue and how to navigate crucial/sensitive conversations. Issues related to cross-cultural competence being embedded within the curriculum rather than being addressed out of context. **Delivery:** Online discussion facilitated by three educators in an international health professions educator fellowship programme. Four scenarios were developed to facilitate cross-cultural conversations.	Foundation for the Advancement of International Medical Education & Research (FAIMER); Maastricht University's School of Health Science Education (SHE)	▲ Consensus regarding the importance of facilitating cross-cultural dialogue ▲ Participants made a case for careful instructional design to explicitly address skills for cross-cultural interaction ▲ Participants described their lack of 'experience in multiculturalism and diversity' as a major barrier to engaging in cross-cultural dialogue ▲ Noted the need to be facile in attending to pain as learners brought up traumatic experiences and other sensitive issues including racism and the impact of power dynamics ▲ Participants were reflective about their own understanding and tendency to be biased

CBPR, community-based participatory research; HCP, healthcare providers; MOU, memorandum of understanding; NGO, non-governmental organisation; UW, University of Wisconsin.

DISCUSSION

Decolonising global health initiatives have largely focused on research and partnerships. This review fills a major gap by synthesising the literature and identifying important gaps that must be addressed to further anticolonial global health education. The articles in this review largely focused on educational approaches for North American students, particularly medical students, to work in other countries with limited findings from Indigenous communities and institutions in LMICs. This review highlights a limited focus in the literature on pedagogy and how global health education tends to privilege and frame as superior Eurocentric/Western systems of health. Furthermore, this review highlights the erasure of Indigenous Peoples within the decolonising global health discussion, as articulated by Jensen *et al*.[19] While this review did not explicitly include 'Indigenous health' in the definition or search terms, the authorship team anticipated that search terms related to 'global health' and 'colonialism' would capture discussion around Indigenous communities, students and knowledge. This content was largely absent from our review. Anticolonial approaches in global health education need to consider alternatives to Western framing by acknowledging different types of knowledge and featuring diverse voices, locally and globally. The Alma Ata Declaration of 1978 has an important anticolonial statement and calls for 'a New International Order', affirming that, 'the people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare'.[69] It also emphasises the role of 'traditional practitioners…suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community'.

This review also shows that among the limited evaluations of educational approaches, there is a focus on the student experience rather than the experience of faculty and global health partners based in LMIC settings. This could be because primary forms of feedback in curricula of HIC settings are from students. Feedback from LMIC partners is key for a curriculum aligned with decolonising global health, however, limited structures are in place to receive these types of feedback. While educational evaluations have changed over time to include input from LMIC partners,[70] it does not yet appear to be featured in the literature on anticolonial global health education. Limited regard for the experience of LMIC partners exacerbates the inequities in educational partnerships and further detracts from students' ability to learn from local expertise and learn what equitable partnerships can look like.

Articles included in this review had little focus on pedagogical approaches and structural changes in educational systems. Most educational content ends at the individual-level (ie, self-awareness and critical self-reflection) and further work is needed to disrupt 'the colonial mindset' in a way that leads to action aimed at colonial institutions and systems.[9] Antioppressive

perspectives (AOPs) acknowledge systemic oppression at multiple levels and challenge individuals to apply their learning by actively addressing power dynamics and impacting social systems.[71] AOPs and related theories can be woven into content and approaches in anticolonial global health education. HIC–LMIC curricular codevelopment is another approach that was identified in this review but has been underexplored and underutilised.[59] Syllabi can also be explicit about the colonial underpinnings of global health and the pedagogical approaches being used as well as the limitations to these approaches (ie, decolonisation is not possible within colonial institutions).

The experiential learning approaches presented in this review were primarily focused on HIC students' engagement with an LMIC host-country, particularly via STEGHs. Current literature questions both the ethics of global health placements and STEGHs,[72 73] and their legality.[74] The results in this review raise concern that global health educators are not adequately adapting to new evidence by reconsidering what experiential learning in global health looks like. This approach also assumes that harm can only occur when global health students are present in LMICs, negating the harm that happens in classrooms, engagements, partnerships and organisational structures, while students are in school and transitioning to their career. More equitable approaches include bidirectional learning such as training opportunities for students from LMICs in HICs, as identified in this review.[42 58]

There must also be a greater emphasis on dismantling systems that promote inequality. For example, there has been a wealth of scholarly activity around creating equitable partnerships with communities and LMIC institutions, yet equitable global health partnerships in education are rarely seen in practice.[75] As a first step, global health actors can look to the pragmatic approaches offered by the Global Health Decolonisation Movement in Africa, or GHDM-Africa, and refuse engagement in, or work to dismantle, unequal partnerships.[76] They can then look towards improvements through equitable distribution of funding, prioritisation of partner needs via ongoing needs assessments, cultural safety promotion and embeddedness in community.[75]

Finally, the reality that Indigenous communities and institutions in LMICs conducting work towards anticolonial education may not be publishing on these experiences in 'academic global health'[14 77] led to a lack of findings which centre their perspectives. Faculty in these settings can face barriers to publication including reduced access to publishing fees[78] and well-documented biases towards publishing their work.[14 79–81] Power imbalances in knowledge sharing may limit the database available to build an anticolonial curriculum in global health unless we address these barriers and expand our resources. Specifically, books by Kovach, Wilson and Windchief and San Pedro discuss Indigenous approaches to decolonising education, pedagogy, epistemology and research that may assist readers in understanding their role within this work and charting an actionable path forward for systems-level change.[3 4 10]

Strengths and limitations

In designing this review, we developed our own definition of anticolonial global health education as an agreed on definition has not yet been developed. However, our definition was developed based on the existing literature and in consultation with coauthors and members of the IDARE committee. We did not conduct a quality assessment on the articles included as it was not necessary for this type of review.[82]

The exclusion of 'Indigenous health' in our definition of anticolonialism in global health education and the search criteria was a limitation of this study. Our initial focus was on educational approaches to address Global North–South relationships, hierarchies and power dynamics and we did not include language specific to regions or communities in our search terms. While some content related to Indigenous approaches to anticolonialism in global health education was captured, we recognise that this is not a comprehensive review of anticolonialism in global health education because it does not explicitly incorporate the Global North–South and Indigenous decolonising global health movements. Based on study results, it is clear this should be a focus for future research.

This article describes a review across all health professions literature and public health. This review was conducted during the current decolonisation movement with new resources emerging regularly. While we sought to ensure the review was updated at the time of publication, it is highly likely that in the process of review and publication, key articles will be missed.

This article's strength is its ability to fill a gap in understanding in the field of anticolonial education in global health. It provides information on where the current literature stands and contributes to the conversation on where the literature must go to ultimately move the decolonisation movement forward.

CONCLUSION

Anticolonial education in global health is essential for addressing structural inequities locally and globally. While there are publications in academic global health discussing proposed guidelines and competencies related to anticolonial public health and describing or evaluating related educational approaches, there is a paucity of literature exploring meaningful pedagogical and systemic change. This review highlights the need for continued exploration and publication within academic global health to build an anticolonial curriculum in the field.

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Contributors HN conceived the study and authored the first draft of the paper in partnership with SP. AK provided mentorship and guidance throughout the study process, coauthored the background, methods and discussion and is the guarantor. PFO contributed to the discussion. SP finalised the paper and all authors reviewed and approved its submission.

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Disclaimer In a discourse about anticolonial education in global health, the authors would like to state their positionality. SP, PFO and AK work for Johns Hopkins University, a Western institution with colonial underpinnings. SP is a white woman of European descent who works for the Centre of Indigenous Health. Her contribution to this paper was interpreted through her lens of Western education and training. She has a commitment to critical introspection and continued learning in her writing and her involvement with community-based participatory research. PFO is a Black African woman who works for the Department of International Health. She recognises the impact of the Western education she has received and draws from the intersectionality of her identity towards an investment in Indigenous and marginalised community-led healthcare development. AK is a white cis-gender woman who works for the Centre for Global Health. She recognises her power and privilege in this space and is dedicated to furthering the field of anticolonial practice in global health education. The authors' intention was to provide a synthesis of existing literature to support this crucial dialogue, with the hope that future work will contribute to structural change within global health education.

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