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Decolonisation initiatives at the Institute of Tropical Medicine, Antwerp, Belgium: ready for change?

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Abstract In a global context, the pernicious effects of colonialism and coloniality are increasingly being recognised in many sectors. As a result, calls to reverse colonial aphasia and amnesia, and decolonise, are getting stronger. This raises a number of questions, particularly for entities that acted as agents of (previous) colonising countries and worked to further the progress of the colonial project: What does decolonisation mean for such historically colonial entities? How can they confront their (forgotten) arsonist past while addressing their current role in maintaining coloniality, at home and abroad? Given the embeddedness of many such entities in current global (power) structures of coloniality, do these entities really want change, and if so, how can such entities redefine their future to ensure that they are and remain 'decolonised'? We attempt to answer these questions, by reflecting on our efforts to think through and start the process of decolonisation at the Institute of Tropical Medicine (ITM) in Antwerp, Belgium. The overarching aim is to contribute to closing the gap in the literature when it comes to documenting practical efforts at decolonisation, particularly in contexts similar to ITM and to share our experience and engage with others who are undertaking or planning to undertake similar initiatives.

SUMMARY BOX

- ⇒ The pernicious effects of colonialism and coloniality are increasingly being recognised across the world, and as a result, calls to decolonise are getting stronger. However, critical reflection on practical efforts to decolonisation is still lacking. Time is ripe to close this gap, as it is shared in this paper.
- ⇒ Although formal colonialism ended many years ago, its effects continue to linger at the Institute of Tropical Medicine (ITM) in Antwerp, Belgium; first, because of its history and roots in colonial medicine, and second, because of the replacement of colonialism by coloniality.
- ⇒ Decolonising global health refers to undoing colonial legacies and coloniality within the discipline and the field. In reality, however, this process is both complex and complicated. Three reasons for this are the continuity between the colonial past and the 'coloniality-laden' present, the ubiquity of modernity, globalisation, and neoliberalism, and the hegemony of Eurocentric epistemology.
- ⇒ Decolonisation in the context of an institute like the ITM requires a 'delinking from the colonial matrix of power', however, this is challenging, given that the decolonisation process and discourse at the institute are entangled in a Western universalistic epistemology. Moreover, decolonising the ITM requires radical change its own being and doing.
- ⇒ The process of decolonising and transforming the ITM, therefore, demands a radical change in the ways of being and doing, which in turn requires a 'fight against', among others, inequity and the power imbalances and epistemic violence that exists in relation to partners in the Global South, within the institute itself and within the broader Belgium context.
- ⇒ Self-critique and reflection are key to this, and the first steps which we hope will lead to a continuous process of (re)negotiating, (re)defining and (re)envisioning what decolonisation at ITM looks like, on what is, after all, a journey rather than a destination.

INTRODUCTION

In her essay 'On babies and bathwater', Rutazibwa, referring to researchers and practitioners of humanitarianism and development studies, talks about 'trying to figure out how to be more efficient firefighters', while 'relentlessly eclipsing the fact that our systems—through us and through those that came before us—have also been those igniting the fires'.[1] She refers to this as the 'disavowal of the firefighter/arsonist (or pyromaniac) conundrum at the heart of how we attempt to 'do good' in the world', and how we teach and study this notion.[1] The same analogy, also evoked by the Ivorian Reggae singer, Tiken Jah Fakoly, in his song 'On a tout compris',[2] in which he highlights the hypocrisy and double standards of African politicians, can be applied to the field of global health where (previous) colonising countries and their agents present themselves as benevolent firefighters who selflessly extinguish the fires that plague formerly colonised nations. They do

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this while conveniently forgetting that they themselves were the arsonists in the first place, and that in many cases, they continue to fuel this figurative fire.

In the field of global health, a collective amnesia and disavowal produces unsympathetic (and unemphatic) responses to problems in formerly colonised nations, which in many cases, are caused or aggravated by colonialism, coloniality (Coloniality is understood here as the 'long-standing patterns of power that emerged as a result of colonialism, but that define culture, labour, intersubjective relations, and knowledge production well beyond the strict limits of colonial administrations') and Eurocentrism.[3] Crucially, the amnesia and disavowal also hinder the problematisation of these three factors.

As it has been highlighted in other reflections on decolonising global health,[4 5] the current approach to global health is a Eurocentric one that is based on a hierarchised view of humanity, and which legitimises the idea that the Western way of being, knowing and doing is universal, and is the objective target of progress and modernity.[5] Quijano conceptualised the universalistic/Eurocentric vision of the world as part of the 'coloniality of power',[6 7] referring to the power structures, control and hegemony that emerged during the industrial and colonial era and are still in operation in form of 'racial, political-economic, social, epistemological, linguistic and gendered hierarchical orders imposed by European colonialism that have transcended 'decolonisation' and continue to oppress in accordance with the needs of pan-capital (economic and cultural/symbolic) accumulation'.[8]

In a global context where there is increasing recognition of the pernicious effects of colonialism and coloniality, demands to reverse this aphasia and amnesia, and ultimately to decolonise, are getting stronger. This raises a number of questions, particularly for entities that acted as agents of (previous) colonising countries and worked to further the progress of the colonial project: First, what does decolonisation mean for such historically colonial entities? Second, how can they confront their (forgotten) arsonist past while addressing their current role in maintaining coloniality, at home and abroad? Third, given the embeddedness of many such entities in current global (power) structures of coloniality, do these entities really want change, and if so, how can such entities redefine their future to ensure that they are and remain decolonised'?

We attempt to answer some of these questions in this paper, by reflecting on and sharing our efforts to think through and start the process of decolonising the Institute of Tropical Medicine (ITM) in Antwerp, Belgium. Answering these questions requires a turn in both ontology and epistemology, which brings the contradictions and ambiguities of global health to light and actively unpacks and counters the variety of ways in which global health was and might still be violent.

This paper starts with the presentation of a brief history of the Institute and the efforts that have or are being made to decolonise it, as well as some of the ongoing challenges. Then, it brings to light some of the contradictions that are inherent to the endeavour of decolonising such an institute.

The paper aims to contribute to closing the gap in the literature when it comes to documenting practical efforts at decolonisation, particularly in contexts similar to ITM. Our overarching goal is to share our experience and engage with others who are undertaking or planning to undertake similar initiatives.

A BRIEF HISTORY OF THE ITM: FROM A COLONIAL PAST TO THE PRESENT

At the end of the 19th century, a new wave of imperialism led to the establishment of geographical societies and institutes of tropical medicine across Europe. The idea to open a school in Belgium was inspired by the founding of the London School of Hygiene and Tropical Medicine (LSHTM), and backed by King Leopold II because of the havoc sleeping sickness was wreaking on the labour force that he was exploiting on rubber plantations.[9]

The institute opened in 1906 with the aim of providing training in 'tropical hygiene' and a specialist training in tropical medicine, which were then not available in conventional medical schools.

Like similar institutes of tropical medicine established in the same period in other European countries, the Institute's founding objectives and philosophy were colonial in nature.[9 10] It was effectively established to serve the interests of Leopold II and later of the Belgian state,[11] and by and large, the institute's mission was to extend Belgium's scientific enterprise to the Belgian colony, with the goal of tackling colonial diseases and contributing to scientific progress in tropical medicine. By 1919, the Institute had started training nurses, missionaries and so-called 'agents sanitaires', who were leaving for the Belgian Congo to implement control measures on major tropical diseases.[9]

In 1933, the Institute was transferred to Antwerp for strategic and practical reasons[9 11] and renamed after Prince Leopold III, because of his special interest in scientific research on tropical diseases/medicine. It thus became 'l'Institut de Médicine Tropicale, Prince Léopold'.[9]

The Institute did not, however, only fulfil a passive, educational function of training medical staff. For example, Jérôme Rodhain who headed the Institute from 1933 until 1947, also served as the medical chief of the Congolese colonial army (Force Publique),[12] and several members of the Institute's board of directors had direct ties to the colonial administration and extractive industry.

The institute could thus be said to have been deeply entangled with and played a central role in the colonial project and Belgium's colonial rule in Congo which was both brutal and exploitative. Congolese people were subjected to oppression and enslavement, and the colonial regimen was notorious for its violence.[13] Metals, rubber and ivory, among others, were extracted through coercive means, including torture, mutilation, and the

murder of those who failed to meet quotas. Estimates of the death toll from systemic violence, disease and starvation under Belgian colonial rule range from 3 to 10 million.[14] In the period leading to Congo's independence, the Institute's overseas work was significantly disrupted,[15] and in the period after independence, its mission of preparing medical staff to work in Belgium's colonies was no longer valid.[16] The institute, therefore, reoriented its educational programme and expertise towards 'development' work in newly independent 'developing countries' around the world. It began to focus on issues like child health, and those related to 'tropical medicine' like malaria, and collaborating with the WHO as well as the Belgian and Dutch international development ministries. The institute's policies also began to be aligned to the goals of the WHO. At the same time, the institute's educational function evolved into 'helping' 'developing' countries by training doctors and nurses and preparing them to work overseas,[17] which gradually led to the adoption of terms like 'scientific or technical support', 'Master in public health' and 'capacity-building'.

In the 1990s, the ITM began to support national and local governments with the setting up of health service delivery systems in Africa, Latin America and Asia. By the end of the century, these international 'partnerships' had become focused on the control of six diseases/pathogens: HIV, tuberculosis, sleeping sickness, leishmaniasis, other zoonoses and (in veterinary medicine) theileriosis. Models and strategies for strengthening health policy in 'developing' countries also began to be developed by the ITM's department of public health.[9]

DECOLONISING THE INSTITUTE: PAST AND PRESENT INITIATIVES

Over the years, a number of decolonial-adjacent initiatives ('decolonial-adjacent' is used in this context to describe initiatives that are ostensibly done with the aim of decolonising and reducing the dominance of the previously colonial entity, but which remain superficial and fall short of their aim, because they do not actively seek to 'interrogate and transform the institutional, structural and epistemological legacies of colonialism')[18] have been undertaken at the institute, particularly around commemorative events (see box 1) in spite of this, however, the idea of decolonisation as it is currently conceived, was immaterial. This changed in 2020.

Campaigns such as 'Rhodes must fall', and the renewed momentum in the 'Black Lives Matter' movement—after the murder of George Floyd—had a huge impact on academic institutes across the world and led to the critical interrogation of coloniality in Northern institutes, such as the ITM. They also led to renewed interest in decolonisation and louder calls for change and reform in global health theory and praxis, in which the remnants of supremacist attitudes, racism and ideology are still deeply embedded.[5] At the ITM, this, together with demands of a growing population of younger, more diverse staff, has provided a window of opportunity for action on decolonising the institute.

Box 1 Decolonial-adjacent initiatives

From 'colonialist' discourse to 'developmentalist' discourse

In 1992, the director of the ITM and the President of the Ethical Committee of the ITM wrote about the institute's strategic efforts to reorient itself away from its colonial mandate. To guarantee its survival in the postcolonial period, the institute widened its focus, moving from tropical medicine, which according to Janssens had an 'emotionally negative image',[17] towards important pathologies and 'travel medicine', as the global tourism market expanded. The focus of the ITM research, according to Gigase, was for 'the benefit of the third world'[10]— it was aimed at 'helping' third-world countries shape their health policies, and producing models and know-how that could be drawn on by international organisations, such as the WHO or the World Bank.

Within this new orientation, however, expertise and knowledge were considered to flow unidirectionally in a North-South direction. Gigase, for example, remarked that 'long-term training in our own laboratories should contribute to the staffing of scientific research in the third world', and 'a larger part of our teaching should perhaps be exported, in agreement with local governments, as refresher courses of a few weeks duration'.[10]

Switching the poles: a disruptive look at development cooperation

In the early 2000s, the director of the ITM introduced a new discourse on 'Switching the Poles', with the goal of rejecting paternalism, and reenvisioning capacity strengthening as being bidirectional in nature.[38]

While this could be considered by some to be a very preliminary attempt at addressing coloniality at the Institute, in reality, it simply reflects the global discourse at the time. For instance, the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, which prioritised country ownership, alignment, harmonisation, results, mutual accountability, inclusive partnerships and capacity development, was adopted in 2005.[39 40] This view is confirmed by the 'Switching the Poles' statement, which underlined ITM's dominant role as the disseminator of wisdom: 'ITM has been investing in the medical and scientific knowledge of its Southern partners for years. We believe this is the only way to create a sustainable, better future'.[41]

In order to unpack colonial legacies and coloniality at the institute, a decolonisation commission was set up by volunteers in 2020 to advise (and support) the ITM in the decolonisation process. The commission is open to all staff of ITM, and no quotas are used. Nevertheless, to ensure that the commission is appropriately constituted and represents all departments and layers of ITM, specific individuals or departments were actively approached to ask if they were interested in and willing to join the commission. Members come from different cultural, academic and educational backgrounds, and at present, the commission is composed of about 15 persons who are staff affiliated to the departments of public health and clinical sciences, or to the international development office, support and technical staff, as well as student representatives. There are currently no commission members

Table 1 Activities

Period	Activities
2021–2022	Raising awareness among the ITM staff and students. An online survey with ITM staff and students to understand their perceptions on the decolonising the institute was organised. 115 respondents participated in the survey and the results were presented at a general ITM seminar in February 2022. The survey questionnaire included closed and open-ended questions: What does decolonisation mean to you? What does the decolonisation of ITM mean to you? Is this a relevant/pressing debate to have at ITM? How should ITM decolonise? Who should be involved? (More details on the survey are on page 14–15)
2021–2023	Teaching about decolonisation. In response to demands from some students of the international health postgraduate programme who were vocal about challenging certain 'Western' analytical frameworks. The working group on decolonising education/curriculum in consultation with the education department of the ITM developed a 2-hour seminar entitle 'Introduction to coloniality and decoloniality in global health'. The aim of the seminar is to raise awareness among students on the relevance of decolonising global health, inviting them to reflect deeper on the subject through reading and group discussion. By the students initiative with the support of some members of the commission, a reading/study group was set up to create space for critical questioning and reflection and to give students a voice. Thanks this reading/study group, interesting and relevant experiences and insights of students were and are stilled captured. The group eventually opened up to include students from the Masters of Public Health course, who do not get the introductory seminar. (See also page 16).
2021–2023	Inventory of the ITM's artefacts. A working group on ITM archives made an inventory of the large collection of material artefacts, including paintings and statues from colonial times, present at ITM. A public event (ITM open day) was organised to allow staff, students and visitors to see, with a critical eye, all our art heritage and give their appreciation of different pieces. A reflection is ongoing as to decide what to do with the artefacts (See also page 17).
2021–2023	Critical reviewing of ITM archives. A research project was started in 2021 to explore ITM's archives, focusing on the history of the institute, its role in the colonial project, and the impacts of this for the present, in terms of research and education. The original project, which would involve interested historians from other universities of Belgium, such as the Catholic University of Leuven, the University of Antwerp and the University of Gent was put on halt because of a lack of funding. Currently, one member of the commission is writing a historical narrative of the ITM (in form of a book) from a decolonial perspective.

ITM, Institute of Tropical Medicine.

from the management level. This was not deliberate but while it is clear that having people from management might have enhanced the commission's clout, this also entails the risk of reducing the commission's ability to criticise and act freely.

The goal of the commission is to consider the implications of colonialism, postcolonialism and coloniality for the ITM in terms of the latter's role and mandate, its organisational values and culture and position in the outside world, and ultimately, to propose recommendations on how to address this. This goal is broken into two objectives which are to (1) reflect on the position and future of the institute and (2) to review and advise on current practices regarding research, education, 'capacity-building' and human resources policies. The commission works on five domains: research, education, artefacts, archives and human resources, and has undertaken a number of activities in each one (see table 1).

ENDURING CONTRADICTIONS AND DILEMMAS

Fighting the fire or 'fanning the flames'?

Although formal colonialism ended many years ago, the lingering legacies of colonialism at the ITM remain invariable and inevitable. The reasons for this are the institute's history and roots in colonial medicine, where the aim was empire expansion and the colonial project; the replacement of colonialism by coloniality; and the general hegemony of Eurocentric ways of being, knowing and doing.[3]

In fact, these legacies of colonialism can already be observed in a number of areas. First, for an institution that wants to cultivate its international profile and 'switch the poles', the management and academic staff is dominated by white and/or people from Western countries, and there are negligible numbers of racialised people and/or those from non-Western countries in such roles.

Second, the ITM has a large collection of colonial or colonial-inspired artefacts. Walls in the corridors and stairways are decorated with paintings and photos that reflect a Eurocentric and colonial vision of African scenes and landscapes, which are marked by racism, orientalism, exoticism and fetishisation. This iconography represents the economy of symbols, which induces mental harassment and feelings of unwelcomeness and inferiority, and reproduces the power imbalance in intellectual life.[19]

Third, in striving to 'spread the sciences that contribute to tropical medicine and to public health', the ITM holds the idea that 'Western science' and 'biomedicine' are the only ways of knowing and doing. Research and education are still embedded in imperial and colonial discourses that influence the gaze of the researcher and the teaching staff,[20] with students being trained in so-called 'state-of-art' public health, clinical or biomedical sciences and

sound methodologies that are underpinned by Western-Eurocentric values and conceptualisations of time, space, subjectivity, gender relations and knowledge. Within this paradigm, indigenous and non-Western-Eurocentric ways of being, knowing and doing are either marginalised and presented as non-mainstream or dismissed as non-scientific.

Fourth, within the framework of 'capacity-building', there is the tendency to view knowledge, skill and competences as being unidirectionally transferred from the ITM to Low and Middle Income Countries (LMICs). Currently, institutional and individual 'capacity-building' projects in 16 countries supervised and supported by the ITM range from the development of educational curricula, to the construction of laboratories and research infrastructure, the training of scientific staff of local partners in good research practices, and research network development, conferences and PhD scholarships. In many of these, the ITM decides on or takes the lead in problem identification, agenda and priority-setting, budget allocation, and how the project is conceived, designed, implemented and evaluated. Commonly, collaborations are developed from relations with former ITM alumni who have been moulded into like-minded partners.

Fifth, the ITM's emphasis on academic achievement may underpin 'the centrality of the role of university education in the future of society […] as institutions of higher learning are, in practice, prime springs of new knowledge and skills'.[21] However, universities in Africa can be seen as 'being semblances of western epistemologies propelling an encumbering and debilitating Eurocentric education, characterised by an attendant tenacity to exclude and marginalise an indigenous presence and 'ways of knowing' in higher education'.[21] As Eurocentric development models and western hegemonic epistemologies are no longer self-evident,[22] aspects of decolonisation touches not only the epistemological foundations of knowledge, but also leads to a 'power-paradox': in order to play a transformative role in processes of change one needs to be heard; in order to be heard one needs to pass though the initiation rites of Masters of Public Health (MPH)- and PhD-studies—and this tension between using the traditional position of the university as a gateway for people to join the elite does not sit easily with the international expectations of decolonial change. In other words, the ITM is instrumental in reproducing not only an imbalance in knowledge models but also imbalance in power relations.

Beyond all this, given the ITM's focus on 'developing countries',[23] the institute runs a very significant risk of continuing to reflect and (re)produce legacies of colonialism, and consequently, 'fanning the flames' of coloniality.

Decolonisation: realistic possibility or a pipe dream?

Decolonising global health simply refers to undoing colonial legacies and coloniality in the discipline. However, in reality, this process is both complex and complicated. One reason for this is the continuity between the colonial past and the 'coloniality-laden' present, and the ubiquity of modernity, globalisation and neoliberalism; three insidious, interlinked Eurocentric ideologies that permeate all spheres of life.[24]

Our first challenge, therefore, was to understand what it means to decolonise—not a, but this colonial institute. If we conceptualise decolonisation as decentring Western Eurocentric ways of being, knowing and doing, and embracing the pluriverse, it becomes evident that for the process to be successful, it must necessarily take into account relations with (former) colonising countries, where the 'coloniality of power' continues to be exercised.[7 20] It should also involve all the members of the institute.

To spark public conversations on decolonisation at the institute, the decolonisation commission developed a survey with the ITM staff and students to understand their perceptions on the decolonisation of the Institute. In 2021, an online survey was launched and included closed and open-ended questions concerning decolonisation as a concept, what it means for the ITM, the relevance of such a debate at the institute, what the process should look like and who should be involved. A total of 115 people responded to the survey. This included 107 staff and 8 students who were affiliated with the three departments and services (Central Policy Office and General Management Office). The results, which were presented at the ITM in February 2022, revealed divergent views on what decolonisation means, as well as its urgency and relevance for the Institute. Tensions and tendencies to polarisation were not absent in the findings of the survey and in the debate after the presentation. This signalled the need for a more in-depth survey, focusing on concrete issues such as racism and discrimination at the ITM; the curriculum, research agenda-setting, methods and policy; capacity-building and the role of partners in the global south; and the training of individuals in the ITM management positions, including top management, heads of departments and unit heads, on issues of race, racism, discrimination, diversity and inclusion. Overall, the survey produced more questions than answers. For instance, who should be involved in determining the meaning of decolonisation for the ITM? Who are the stakeholders? What does decolonisation mean within our specific context, which is Belgium, Flanders province, the city of Antwerp, the ITM? Is decolonisation inward-looking, outward-looking or both? Should it focus on Belgium or should it be broader to include the ITM's international partners in the global South? And considering the past and the present, is decolonisation at the ITM even possible or is it merely a pipe dream?

The commission also made efforts to engage students in the decolonisation debate and process, for instance, through initiatives that aim to obtain their views on the curriculum, on power relations between students and lecturers, visualisations and representations of LMICs in

lectures, lecturers and other issues related to the curriculum. Furthermore, a 2-hour seminar on 'coloniality and decolonisation in global health' was initiated in 2020 and is offered to Introduction to International Health (IIH) students who are mainly from high income countries (HICs). This initiative was demanded by IIH themselves. Students from the MPH, the majority of whom are from LMICs, do not yet receive this course and have not proactively demanded for it. Each year, there is also an extracurricular reading group on coloniality and decolonising in global health. These initiatives, however, remain rather limited in nature, mainly because not enough time or other resources are dedicated to them, and they do not cover the entire student population.

In any case, decolonising education would require going some steps further and undertaking activities such as incorporating historical and longitudinal perspectives in teaching, in order to expose injustice and structural determinants; reviewing the staff composition and the selection and portrayal of role models and student mentors; reflecting on and reviewing the use of images, discourse and artefacts in the curricula; acknowledging the hierarchy of knowledge and presenting different forms and perspectives on knowledge; and offering staff training on reflexivity, decolonisation practices and antiracism.

A critical look at the ITM's research systems, that is, claims and assumptions of epistemological universality and researching the 'other' also raises several questions: Who decides on the priorities, sets the agenda and determines research topics? What research methods are being used and who determines them? What about authorship and what this means for equity and the quality of the knowledge that is being (re)produced? How does one deal with the dilemma of research 'excellence' versus relevance in research collaboration with institutes/universities in LMICs? And how should power asymmetries in research funding, publication, citation, etc be addressed?

Decolonising research at the institute would require for instance ensuring that an examination of power dynamics and its effect on equities and social justice is included in the ethical review process of research proposals; priority-setting is done or led by partner institutions in the South, and there is proactive support for embedded research; there is a focus on participatory methodologies and cocreation, and better accountability for the overall research funding process which means grappling and actively critiquing the political economy of global health research.

The final issue is the ITM's colonial artefacts, some of which have been classified as part of the institute's patrimony or 'heritage'. The questions here focus on the circumstances in which these artistic 'heritages' were brought to the ITM that is, were they gifts, bought or 'stolen'? What is the value of this 'heritage'? Does this value mean it can be put on display, even at the expense of real people and at the risk of reproducing an atmosphere of domination? So far, these questions have not been part of the ITM's narrative about its artefacts.

Discourse versus reality: a desire for symbolic rather than structural changes?

The commission on decolonisation at the ITM is composed of volunteers, and while this is the case in many former colonial institutes,[20 25 26] it is clear that compared with some, ITM is lagging behind when it comes to the resources that are being dedicated to decolonising the institute.

For instance, the governing body of the LSHTM responded to staff and student complaints, by commissioning a consultancy—the Nous Group, to make a critical inquiry into its colonial past, and address racism and discrimination. This was done through the Diversity and Inclusion Committee, and independent of the management.[27 28]

Focusing on racism, inequality and colonial legacies at the school, the Nous Group also explored how 'colonial attitudes inherent in LSHTM's historical mission negatively impact students and staff of colour today'.[29]

In another example, while decolonisation at the Institute of Development Policy (IOB) of the University of Antwerp, Belgium, is mainly volunteer led, with students playing a significant role,[25] there is some institutional support for the work. For instance, decolonisation was the subject of one of the IOB Seminar Series which is coordinated by paid staff. In addition, in focusing on the challenges facing the institute in its efforts to decolonise, an IOB researcher was allocated time and other resources to conduct research in a wider set of literature. The outcome was a (self-)critical report, which presented the lessons learn and gave recommendations on what should be done to improve current practices.[25]

In contrast to these two cases, the decolonisation project at the ITM does not have institutional support and commitment, or investment in resources. This has stymied the progress of the process, as people have to either do this work on their weekends or during their already-packed working hours, which in turn has had an impact on motivation, particularly since very little value is ascribed to this service.

We also encountered challenges in other areas. For instance, there was some resistance from the education department with including decolonisation on the curriculum, which was formulated around the difficulties of finding space for this topic on an already overcrowded curriculum. Additionally, we faced some reticence from MPH students (predominantly from LMICs) who seemed unwilling to engage with the subject. This was unexpected, especially given the enthusiasm that was expressed by students from the IIH course (predominantly from non-LMICs). In reflecting on the reasons for this, we had to grapple with the issue of power balances, in this case, students being asked to engage in an activity that could be perceived as being critical to the institution and/or country that funds their education.

The question then is not, should not decolonisation be incorporated in the whole curriculum as an overarching teaching framework as current discussions on decolonising universities suggest[30–32] ? Rather, going one step further, it should be: shouldn't the current system of building new academic elites, itself, be interrogated?

Given all this, the question then is, is the decolonisation of the ITM even possible at all?

Satisfactory solutions to these challenges and answers to these questions have not yet been found. Nonetheless, one thing that has become clear to us is that, for sustainable decolonisation to occur, there must, first and foremost, be a radical change in mindsets at both the institutional and individual levels, and in this, the concept of 'decolonising the mind', first used by the Kenyan novelist Ngugi wa Thiong'o can be useful.[33] Although Ngugi's focus was on the role of African languages in postcolonial literature, that is, the need to replace European languages by indigenous languages in the literature of former-colonised countries, his understanding of coloniality as control of the mental universe and worldviews of former colonies remains relevant to the decoloniality project at the ITM. In effect, the institute must decolonise its figurative mind.

CONCLUSIONS

Eurocentric hegemony[34] remains a dilemma in grappling with the ITM's decolonisation process. Our decolonisation discourse itself is entangled in a Western universalistic epistemology, and the attempt to decolonise the institute has thrown up more questions than have been answered. How can the decolonisation commission engage with and address supremacist paradigms in global health research and education[5] ? As a global health institute, how does the ITM engage with the epistemic tensions between Western biomedicine and indigenous medicines[35] ? As researchers based in an HIC, how do we avoid the 'taking ownership' of intellectual decolonisation while silencing scholars from LMICs[36] ? Does our 'taking the lead' in decolonisation not produce a form of 'rewesternisation disguised as decolonisation'[34] ? How do we deal with the idea of us as Western people leading non-Western people in the fight against oppressive structures including racism and colonialism/coloniality[37] ?

Decolonisation in the context of an institute like the ITM is a process of self-critique and reflection that leads to a continuous awareness of, and fight against, inequity. It is a journey rather than a destination. There are many pitfalls in the process that we and others undertaking this path need to be aware of. The ITM will have to manoeuvre between a whole set of intersecting paradoxes, such as the 'universalness of universities' versus the local roots of local knowledge; the European and more particularly the Belgian and Flemish settings of the ITM versus other settings in continents such as different as Africa, Asia and Latin America; the power challenges that will, inevitably, arise as change occurs; the interaction between social and political identities like gender, race, social class, income, etc, and how these combine, overlap and intersect to create either inequity or privilege; the difference between science that wants to grasp reality and science that wants to change reality; the meaning of equal partnerships in a context where funding flows from North to South; the question of excellence versus relevance; and last but not least, our positionality as people attempting to decolonise our own institute.

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Author note Authorial reflexivity: Given the subject of this article, we believe it is necessary to reflect on our positionality as authors, and to reflect on and acknowledge how our identities and subjectivities shape our thinking, our work and our viewpoints. We all occupy insider/outsider positions to greater or lesser degrees. While the countries of origin of two of the authors are previously-colonised countries, we all have citizenships of European countries. We all work at an institute of tropical medicine in a previous colonising country, attended higher education in European universities and are active in the field of global health. While we actively engage with critical, decolonial and postcolonial theories, none of us is trained in or an expert in the field. This implies that our own (academic) foundations, traditions and frames of reference are rooted in European thought. The categories and concepts we employ are therefore partial and limited, and inevitably bias our questions, methods and agenda in both conscious and unconscious ways. The fact that we all work at the ITM not only allows a thorough and critical perspective from within but it also means that our perspective is homogenous and academic in the way it addresses the discussed issue. Finally, while this paper applies a critical race theory lens, it is a narrative review that draws on the lived experience of most of the authors, and as such, we recognise that our positioning is normative. In the light of all this, we acknowledge the limitations of our work.

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