

Inception Report

RACIAL DIVERSITY IN GLOBAL HEALTH

*From Rhetoric to Tangible Change:
Pitfalls and Opportunities*



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Authors: Gisa Dang, Dr Fifa Rahman, and Nyasha Chingore-Munazvo

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This report was written and published through an ongoing initiative on race and global public health between AIDS and Rights Alliance for Southern Africa (ARASA) and Matahari Global Solutions. An Inception Roundtable on 25 February 2021 marked the official launch of this race and global health initiative. The Inception Roundtable was held under Chatham House Rules and quotes and statements are not attributed to individuals for that reason. Some participants remain anonymous.

ARASA and Matahari Global Solutions recognise the tireless efforts of all peoples working on tackling structural racism globally. We acknowledge racial and gender minorities working in the global health space, and communities living with diseases. We would like to thank everyone who contributed to the Inception Roundtable and this report, including ARASA staff members Paleni, He-Jin, and Soraya; Dr. Sharifah Sekalala; and our Advisory Committee. Our thanks go to Open Society Foundations for their initial funding and support of our concept.

We are especially indebted to everyone who contributed to the rich and frank discussion at the Inception Roundtable held on 25th February 2021. Participants of this roundtable were as follows:

Participants of the Inception Roundtable

Allan Maleche; Anu Kumar; Colleen Daniels; OA; Kreeneshni Govender; Linda Mafu; George Ayala; Vuyiseka Dubula; Stellah Wairimu; Madhukar Pai; Luiz Carlos Silva Faria Junior; Priti Radha Krishtel; 789; Divya Bajpai; Lola Abayomi; Loyce Pace; Samanta Tresha Lalla-Edward; Nyasha Chingore-Munazvo; Felicita Hikuam; Fifa Rahman.

Their quotes, insights, and lived experiences are highlighted throughout this report and formed the foundation of this report and the framework for the in-depth study.

ARASA was established in 2002 and is a regional partnership of over 100 non-governmental organisations (NGOs) working together in 18 countries in southern and east Africa, to promote a human rights approach to HIV, AIDS and tuberculosis (TB) through capacity strengthening and advocacy. ARASA's vision is to promote respect for and the protection of the rights to bodily autonomy and integrity for all in order to reduce inequality, especially gender inequality and promote health, dignity and well-being for sustainable development in southern and east Africa.

Matahari Global Solutions is a research and policy group registered in Kuala Lumpur, intended to ensure Global South voices and evidence is integrated into policy and Global North decision-making processes. Established in 2020, Matahari provides global health policy and research services, monitoring and evaluation, and civil society support. We are a team of 5 consultants based in San Diego, Leeds, Rio de Janeiro, Moscow, and Jakarta. Recent projects include documenting the COVID-19 response in Brazil; analysis of the COVID-19 response and impact on HIV and TB Services in Eastern Europe and Central Asia; and documenting transgender conversion therapy in Malaysia.

ARASA

53 Mont Blanc Street

Windhoek, Namibia

Telephone: + 264 (61) 300381

Email: communications@arasa.info

Website: www.arasa.info

Matahari Global Solutions

No. 39-3, Jalan Wangsa Setia 1

53300 Kuala Lumpur, Malaysia

[This is the registered address -
consultants are not physically
based in this location]

Email: frahman@matahari.global

Website: <http://matahari.global>

BIPOC	Black, Indigenous, and people of colour. This term is commonly used in a US-centric discourse on race. The conversation in the Inception Roundtable did not use this term, which is why it does not appear in this report.
Black and Brown people	Participants used these terms in the Inception Roundtable discussion, which is why they are the default terms in this report. This report uses Black capitalized in accordance with AP style. We capitalize Brown as well to give equal emphasis to all people of colour.
Colour blindness	<p>Colour blindness is the belief that everyone has equal opportunities and that everyone is equal regardless of their skin colour, which lead to the belief that racism and unequal opportunities based on race no longer exist. Colour blindness is also called colour evasiveness, because it prevents us from seeing the historical causes of racial inequality and how racial inequality persists in our society.</p> <p>Diversity, equity and inclusion is a phrase commonly used in discourse on human resources and race to denote strategies of integration.</p>
White privilege	White privilege means the inherent social and economic advantages possessed by a white person on the basis of their race in a society characterized by racial inequality and injustice.
White supremacy	This report, and our initiative, uses the term white supremacy in line with the definition in Layla F. Saad's book <i>Me and White Supremacy</i> . White supremacy surpasses an individual's notion of right wing extremism or a white power ideal, to include the structures, norms, and rules created by a white-centred society, i.e. a society (or organization) in which white people hold most positions of power.

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Racism and white supremacy in global health are well-documented. On 25th February 2021, 20 Black and Brown global health leaders, including communities living with the diseases, convened in an inception roundtable organized by Matahari Global Solutions and the AIDS and Rights Alliance for Southern Africa (ARASA). The purpose of this roundtable was to discuss the effects of racism and white supremacy in global health, and thereon the parameters of an in-depth study on the same, and how to change rhetoric on diversity and equality to reality. This report documents the discussion.

Our global health is unglobal. This meaning of this statement has become extremely obvious in light of the inequities people around the world are experiencing in the ongoing COVID-19 pandemic. Attention to racism in many industries across the globe has been growing in recent years and was amplified after the murder of George Floyd in 2020. The legacies of colonialism, apartheid, and slavery run deep in many aspects of the world we live in today. They are apparent in many locations across the globe and across many layers of our societies, including governments, education, and our workplaces. Global health, with its roots in tropical medicine to uphold colonialism, is one area where these legacies have influenced the structures of how we work, what questions we seek to address, and how we go about addressing them.

For the purposes of this report, white supremacy does not exclusively refer to nationalist right-wing extremists and anti-Black violence. Rather, white supremacy exists through structures that have been moulded by white people, who, courtesy of these structures, maintain the power to set guidelines that impact the lives of many people. These structures and their power dynamics reinforce conscious and unconscious racial biases. In contrast to the overall workforce of predominantly Black and Brown women from the Global South, global health is predominantly lead by white men.

In order to develop actionable recommendations to dismantle racism in global health and build a Black and Brown people-centred vehicle to create institutional shift, cultural policy and push for its implementation, ARASA and Matahari launched this initiative by centring Black and Brown global health professionals, including communities living with the diseases, in the Inception Roundtable. The purpose of the roundtable was to take stock of experiences of racism and white supremacy in global health. The second purpose was to set the parameters for a body of qualitative and quantitative research that cements the data for feeding up-to-date insights for policy recommendations and advocacy missions. This report represents both the summary of that meeting and the justification for the research framework our organizations will implement with the support of an advisory committee made up of Roundtable invitees over mid-2021. A research report with recommendations will follow before the end of 2021.

This report will also outline additional research questions that our team and others would like to include going forward to form a more complete picture and allow for a sustained shift rather than short-term reactions that will not change how global health functions. The 20 Black and Brown participants described the current state of global health as neocolonial and imperialistic, unequal, high-income dominated, limited, and defensive. They pointed to pressing challenges in hiring and recruitment; governance and leadership; and high-income countries, including funders, dominating every aspect of global health. These challenges originate in racism towards Black, brown, and Indigenous people of color in countries in the Global North; as well as racism inherent in actors from the Global North towards persons from the Global South. Participants warned that while there currently is a focus on decolonization of global health, following the growing Black Lives Matter movement, we must avoid this moment culminating in co-option or tokenistic engagement that will not last.

Repeatedly, participants pointed to the absence of white voices in dismantling racism in global health. “White people cannot expect those who are oppressed to change a system of oppression, which was made by and sustained by them. These are important issues for white people to address.” Guided by a collection of quotes from the Inception Roundtable live discussion and chat forum, this report explores the following themes:

- Individual versus systemic change
- The ambivalence of white supremacy
- Language and racism
- Leadership, human resources, and DEI
- Knowledge and truth in the global health space
- Funding and philanthropy
- Tokenism and the moment of wokeness
- Silencing and intersectionality

A two-hour discussion was of course inadequate to do any of these topics justice. At the same time, it provided a comprehensive overview of themes that require further exploration if we want to ultimately dismantle racism and white supremacy in global health. The report includes a list of potential research questions for the initiative and others to explore. For the initiative’s research plans in 2021, however, this continued request for white allyship stood out. In other words, to dismantle racism and white supremacy in global health, we need supportive white allies vocally being anti-racist and promoting anti-racism in global health.

Since the Roundtable, ARASA, Matahari, and our research partner at Ezintsha at Wits University have submitted a research proposal for ethics review that includes interviews with white leadership of Global North organizations, interviews with Black and Brown global health professionals, and an additional survey among key informants. This qualitative study embarks from the assumption that racism in global health exists, and therefore aims to explore why current interventions are not working, and what behaviour changes are needed to enable successful DEI frameworks. The research will examine the perspective of white leadership about institutional racism in their organisations; the experience of Black and Brown people with racism and allyship in their organisations; and identify challenges and roadblocks to successful anti-racism policies in global health institutions.

“Global health inherently is contradictory. We want to reduce inequities but in practice global health was birthed in supremacy and it continues to be dominated by white supremacy.”

The legacies of colonialism, apartheid, and slavery run deep in many aspects of the world we live in today. They are apparent in many locations across the globe and across many layers of our societies, including governments, education, and our workplaces. Global health is one area where these legacies have influenced the structures of how we work, what questions we seek to address, and how we go about addressing them. COVID-19 has made obvious to the world what many in global health have been experiencing for a long time. Inequities exist in access to treatment, diagnostics and preventative measures; and race often determines the amount of accessibility, acceptability, availability, and quality of the services delivered through public health structures.

Our global health is unglobal. In this new initiative,¹ ARASA and Matahari Global Solutions are focusing on the effects of racism and white supremacy culture in global health. It is important that we recognize that white supremacy does not exclusively refer to nationalist right-wing extremists and anti-Black violence. Rather, that “in white-centred societies and communities, [white supremacy] is the dominant paradigm that forms the foundations from which norms, rules, and laws are created.”² White supremacy, therefore, exists through structures that have been moulded by white people, who, courtesy of these structures, maintain the power to set guidelines that impact the lives of many people. These structures and their power dynamics reinforce conscious and unconscious racial biases.

The origin of global health dates back to colonial times, when ‘tropical medicine’ was established in late 19th century Britain as an active tool of maintaining the Empire. Its ‘usefulness’ in this regard was recognised by other European states, who employed this tool in the formation and maintenance of their own empires.³ Structural racism was built in from the beginning, and today’s global health is still predominantly lead by white, elite men,⁴ in contrast to the overall workforce of predominantly Black and Brown women from the Global

¹ For an introduction to our analysis of racism in global health, please see e.g. <https://healthpolicy-watch.news/misrepresented-our-global-health-is-unglobal/>

² Layla F. Saad, *Me and White Supremacy* (Sourcebooks 2020) pp. 12ff.

³ See e.g. Kelley Lee, ‘Understandings of Global Health Governance: The Contested Landscape’ *Global Health Governance: Crisis, Institutions and Political Economy*. PALGRAVE MACMILLAN, UK. p. 37; Lucinda Cash-Gibson, Diego F. Rojas-Gualdrón, Juan M. Pericàs, Joan Benach. ‘Inequalities in global health inequalities research: A 50-year bibliometric analysis (1966-2015)’. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0191901>. Accessed 24 June 2020

⁴ Katrin Bertram, Ngozi Erundu, and Madhukar Pai, ‘Silenced Voices in Global Health’ *Think Global Health* (3 June 2020). <https://www.thinkglobalhealth.org/article/silenced-voices-global-health>. Accessed 9 June 2020

South.⁵ Discussions of global health continuing colonial relationships and furthering economic interests of former colonial powers are supported by numerous examples of continued underrepresentation of the Global South. The heads of key multilateral global health agencies (notably Global Fund, Unitaid, Gavi, and CEPI) and their senior management teams are predominantly white and from the Global North. In fact, a survey of 198 global health organisations showed that nearly 90% are headquartered in North America or Western Europe.⁶ Democratic deficits contributed to by a lack of diversity in decision-making positions have been shown also to distort local priorities, in addition to failing to effectively gain information from the most excluded segments of communities in-country.⁷

In order to present actionable recommendations and build a Black and Brown people-centred vehicle to create institutional shift, cultural policy and push for its implementation, ARASA and Matahari decided to start the initiative by centring Black and Brown global health professionals, including communities living with the diseases, in an Inception Roundtable that was to set the parameters of the qualitative and quantitative research that cements the data for feeding up-to-date insights for policy recommendations and advocacy missions. This Inception Roundtable commenced on 25 February 2021 as an online meeting. This report represents both the summary of that meeting and the justification for the research framework our organizations will implement with the support of an advisory committee made up of Roundtable invitees over mid-2021. A research report with recommendations will follow before the end of 2021. This report will also outline additional research questions that our team and others would like to include going forward to form a more complete picture and allow for a sustained shift rather than short-term reactions that will not change how global health functions.

5 Roopa Dhat, 'Global health security depends on women.' <https://www.devex.com/news/opinion-global-health-security-depends-on-women-96861>. Accessed 24 June 2020

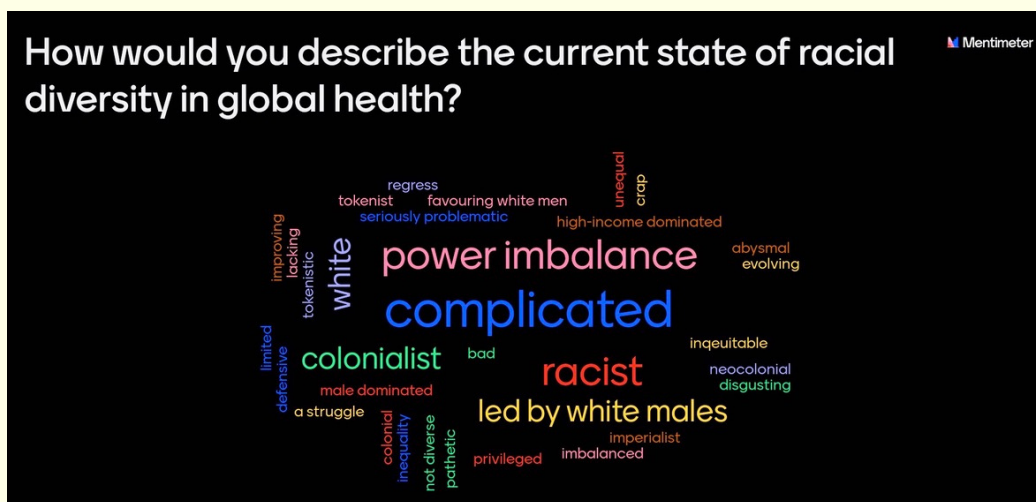
6 Global Health 50/50, 'The Global Health 50/50 Report 2020: Power, Privilege and Priorities' (London: 2020) p. 19

7 Sharifah Rahma Sekalala, 'Who Gets to Sit at the Table? Interrogating the Failure of Participatory Approaches within a Right to Health Framework' (2017) 21(7) The International Journal of Human Rights 976-1001

Summary of Roundtable Discussion

A series of brainstorming questions using the online tool MentiMeter⁸ set the scene and illustrated how profoundly white supremacy and colonialism continue to shape the field of global health. These questions were designed to work as ice-breakers and to take stock of attitudes among the participants. Please see images of the responses to the three questions below.

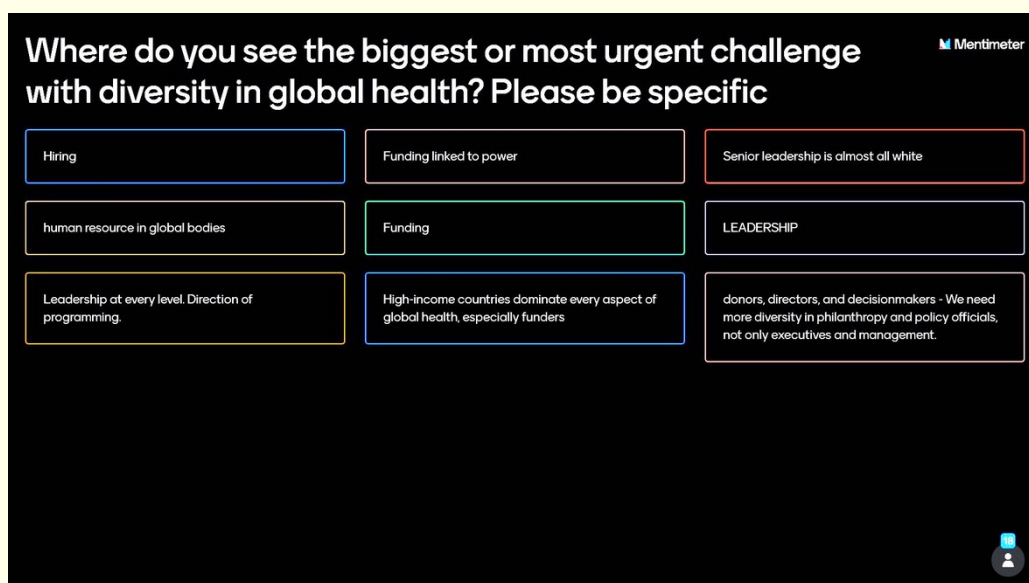
MentiMeter Results for Question 1: How would you describe the current state of racial diversity in global health?



Complicated, racist, colonialist, power imbalance and led by white males were the main sentiments initially expressed, with nods to inequality and inequity, and struggle. Some participants also shared their frustration through the wording they chose, while some saw change by pointing to global health as an evolving and improving field.

MentiMeter Results for Question 2: Where do you see the biggest or most urgent challenge with diversity in global health? Please be specific.

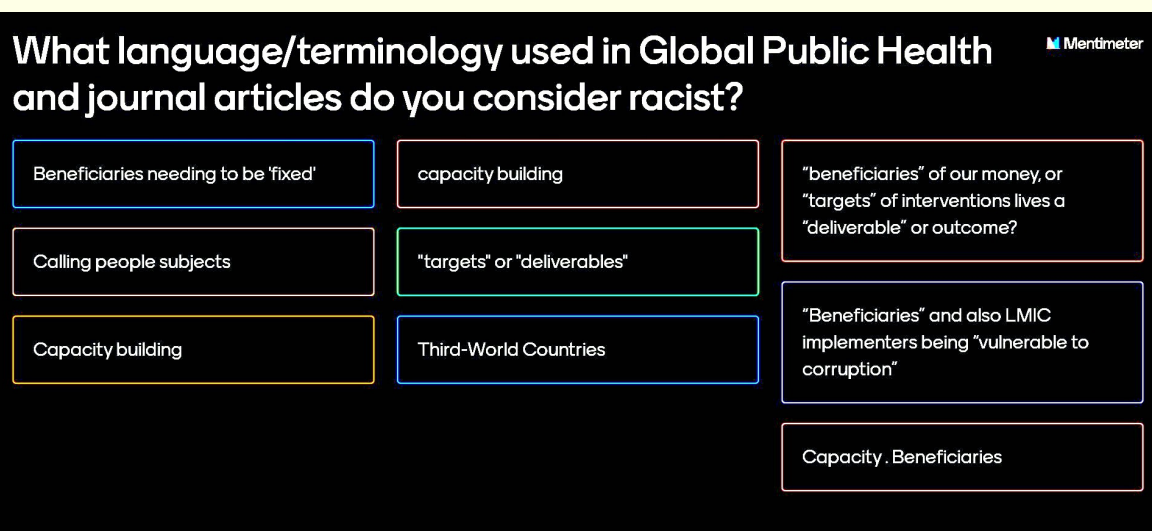
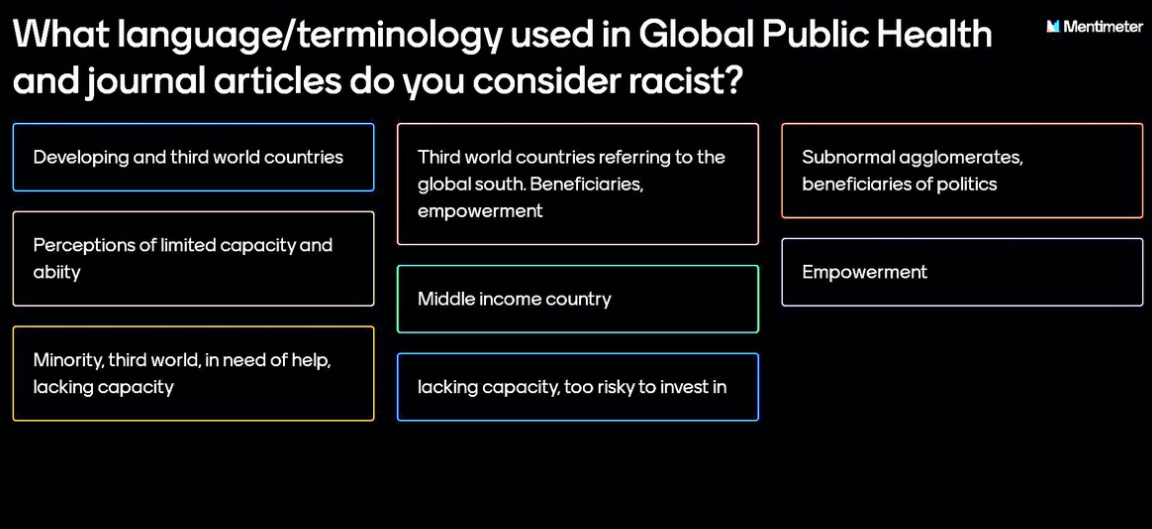




Main themes for the second question about urgent and important challenges with diversity include lack of diversity in philanthropic funding and its connection to decision-making power; hiring, recruitment, and governance in global organizations; lack of diversity in thought leadership and programmatic direction; and non-diverse leadership.

MentiMeter results for Question 3: What language/terminology used in Global Public Health and journal articles do you consider racist?

The last brainstorming question, about commonly used language in global health practice and publications that participants considered racist, was originally meant to aid the team in developing an unbiased, preferred terminology for the initiative. However, the responses presented an urgent appeal to the global health community to question the terminology used daily in global health and to re-define terminology that is not loaded with colonial and white supremacy undertones. For example, the word 'beneficiaries' was seen as colonial. The answers also present a stark reminder that white supremacy culture is certainly all-encompassing and a daily experience for Black and Brown people.



Responses overwhelmingly pointed towards implicit biases towards Black and Brown people e.g. with the term capacity building exuding expectations of low capacity and ability, in need of help, and also risky for investment. Other dehumanizing aspects of terminology were also mentioned, for example calling people subjects, targets or beneficiaries of interventions in which lives are seen as deliverables. The terms third world and developing world were also named as connected to low expectations and racial bias.

“White people cannot expect those who are oppressed to change a system of oppression. These are important issues for white people to address.”

~ individual vs. systemic change ~

Participants said that global health is inherently contradictory. As pointed out in the introduction, global health originates from colonization, which has touched every country one way or another. Colonialism and its outgrowths were a racist, white supremacist enterprise. How could we expect that global health today is untouched by its past? One participant said that global health “wants to reduce inequities, but in practice it was birthed in supremacy and it continues to be dominated by white supremacy.” A large part of the Roundtable discussion centred around the challenges of individual versus systemic change. Alongside this, participants made the point that there exists a tension in who holds responsibility versus who takes responsibility. Three main questions came up: “How can we decolonize ourselves?” “How can we decolonize our organizations and systems?” and “Who is responsible for making these changes?”

Numerous participants pointed out that for an individual Black or Brown person, it is challenging to point out racism in the workplace and that fear of retaliation is real. Standing up and standing out usually leads to two types of responses. Response one encompasses strong retaliation. Individuals are threatened, employees are harassed, and experience little to no public support. Response number two requires the person who called out racism to take the lead of the diversity program set up in response. In the end, this results in shutting down individuals and their complaints, because they are now busy running the new diversity, equity and inclusion (DEI) program. Participants felt strongly that when racism is called out, there is an unspoken agreement that Black and Brown people have to carry the burden of changing a problem they did not create. In these instances, recounted for both academic and global health organizational settings, “it is to use our energy engaging in that discussion instead of doing the work to dismantle and address the problem.”

Participants felt strongly that it is important to recognize that “we have to move on from ‘the first’”. How is a single story going to change an institution, for example the WTO? Yet we are made to believe it will.” At the same time, participants did feel that individuals with agency can make incremental changes, indeed must work on decolonizing themselves, and through themselves, their organizations and others around them.

In practice, all individuals with agency can make choices to lean out, to step back from invitations to e.g. present at a conference, and instead suggest Black or Brown persons that can speak. Individuals can make an effort to exit what participants dubbed the “white narcissistic pact” that centres white male representatives. In a field where much of the programmatic work takes place in the Global South, there are many competent Global South individuals. They are not those in positions of power, so they don’t get seen.

“We’ve been struggling for many decades how to thread this together’, one participant said of moving from individual to systemic change. “There is generational trauma. [We see this] even in progressive spaces like social movements in the Global South, how people have internalized decades of practice and think that should be the norm.” How then can we decolonize our global health institutions and systems? A common sentiment arouse around self-preserving instincts of institutions: power fights back; power wants to keep power at all costs. “We are up against a massive mountain. This animal is so massive, I don’t even know where to begin. Could you ask for a stronger illustration of global inequities as COVID? We cannot even get closed to equity in vaccine distribution, how can we change organizations?.

And yet, we have reason to be optimistic. Communities are holding boards accountable and some people in power are taking notice. “Some CEOs are listening.” One way is to find support for those who are alienated if they dare to challenge the structure of power. Individuals need to be able to safely call out racism in institutions and practice. What support is needed and how to build that support remains an important question. At the same time, organizations can begin by questioning some of their practices. They can review how they award their consultancies and collect data on who they hire and who they pay. For large international organizations including at the UN level, it is obvious that the same group of experts get hired across many organizations.

A practical example of going beyond rhetoric in recruitment came from a recent vacancy notice by a European organization. While the vacancy notice explicitly said that everyone was encouraged to apply, the same notice limited applicants to certain passport holders, effectively hindering people from the Global South to apply and leading to the current situation where certain groups of people are overrepresented. This is the type of evidence that individuals within and outside of organizations can present to ask for concrete, systemic change. Actions like this actively influence who gets to sit at the table and who is part of these discussions. Recruitment practices also influence at what stage people from the Global South get engaged in addressing global health practice. They do not commonly get engaged from the start, not in internal institutional discussion, but later when external dialogues begin. At that point, the role for Global South representatives feels like the role of begging for support. They are not seen as bringing specific knowledge from their countries nor as those with the expertise.

In the words of a participant, “we know there is systemic racism in our global health organizations. Black and Brown people have been talking about [experiencing this] trauma. I don’t see white people talking about what is their role in holding up systemic racism.”

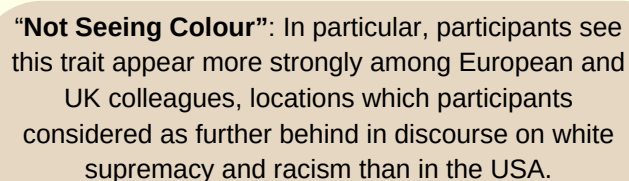
“White liberals are allies until their privilege is threatened.”

~ the ambivalence of white supremacy ~

There were many moments in the Roundtable discussion when participants returned to a major impediment to creating change in the current system, i.e. the role of white people, especially those in positions of power. Herein lies the main challenge not only for global health, but for all systems that want to challenge their white supremacy culture. “White men are reaping the benefits of the system, why would they want it to change? It's their world, we are just living in it.” Participants pointed out the existence of what to Black and Brown people feels like a white boys' network in global organizations and even governing bodies. The recognition that Black and Brown people “don't have the social capital and boardroom capital to be recognized in those spaces” was a strong undertone throughout the Roundtable discussion.

Participants connected the lack of progress towards racial representation to the ‘myth of the white liberal’. This myth signifies the idea that substantial progress towards racial justice is hindered by white moderates, who may agree with the goal of racial justice and equity in theory, but in reality criticize and counter methods to progress.⁹ “They occupy every level in global public health. The liberals who will share a BLM meme on social media but fight tooth and nail to prevent any change in their lives.” This was not a localized experience. Among the participants, it was also dubbed the “whiteness narcissistic pact”.

Participants recounted experiences with several common phrases and behaviours that uphold white supremacy. One phrase is “We don't see colour.” In particular, participants see this trait appear more strongly among European and UK colleagues, regions which participants considered further behind in their discourse on white supremacy and racism than the USA.



“Not Seeing Colour”: In particular, participants see this trait appear more strongly among European and UK colleagues, locations which participants considered as further behind in discourse on white supremacy and racism than in the USA.

One participant emphasised: “The problem lies in the fact that “if you don't see colour, you don't see racism and privilege”, i.e. that experiences of individual and systemic racism do not get recognized as what they are. As long as that happens, racism cannot be effectively addressed. It appears that this notion is closely related to the fear of white people that they may be seen as being racist, which is used as an excuse to not move against structural racism. In fact, participants expressed that it would be “a huge contribution to get the Europeans talking about this [i.e. racism and white supremacy].”

⁹ Martin Luther King, Jr. wrote about the phenomenon of the white moderate in his “Letter from a Birmingham Jail”, dated 16. April 1963. See. e.g. https://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html

Global health institutions of course harbour multiple layers of racism. Overt or implicit racism and bias are not solely expressed by white people. Participants identifying as Brown observed that while they were on the receiving end of racism, they also observed themselves and their peers being racist. One of the ways this happens is by centring whiteness. White supremacy culture means that closeness to whiteness gets rewarded, which encourages racist views and actions e.g. by Asians against Black people.

In order to move away from centring whiteness and white-originating norms and practices, participants agreed that to get lasting change it would be critical to ultimately get white men, in particular those who hold the purse strings, to join the discourse. Participants observed that similar people often appear in meetings and conferences on decolonization of public health. However, “we are nowhere close to catching the pinnacle of power, white men from high-income countries. How many white men do we know who are willing to do the hard work and enact changes? What will it take for them to show up at these meetings, to say the right things and to do the right things?”

“Sometimes the lack of reference to race is racist”

~ language and racism ~

The discussion about the lack of white allies linked closely with another well-established phenomenon that participants pointed to: white silence. White silence is the absence of supportive public statements of white people in face of racist experiences or systemic racism by their Black or Brown colleagues. Indeed, in the ensuing discussion on the research focus repeatedly requested a closer look at white allyship. What moves white employees to publicly act as an ally, to what extent are allies present in organizations, and what support or framework would make more people take the steps from silence to allyship?

Participants observed that “the silence says a lot”, and “white silence = white consent”. Justifications for staying silent encompass many, including the fear of being seen as racist and “not seeing colour”, i.e. colour blindness. Not seeing colour and fear of being perceived as racist, rather than the fear of actually being a racist, affect the language that individuals and organizations use in their interactions and statements. For example, participants pointed to the persistent use of ‘non-white’, as if there is just one race aside from being white. This was perceived as othering, i.e. that “there is “being white and the rest is ‘other’.”

Another example along the same line of othering and lumping a large diversity of people into one group was the remark that resonated with most participants: “Do you know Anna from Africa?” Similarly, the expression ‘the voiceless’ came up in the discussion. Dubbing a large community of people as voiceless in reality was perceived not as this community actually being voiceless but as instead being ‘silenced’. Language and terminology definitely in an area that needs to be reassessed in the global health context.

“Institutional change is more likely to come with Black and Brown people in CEO jobs and on Boards.”

~ leadership, human resources, and DEI ~

From the different discussion threads, a question emerged on how organizational leadership and human resources professionals in large institutions perceive DEI and how they operationalize these concepts. Participants reflected that while there was recognition of a growing courage to call out racism in global health organizations, especially by women of colour. These incidents are usually followed by “a flood of DEI pledges and written statements.”

Sometimes, institutions install a DEI ombudsperson or office. While it may be too early to tell how effective these pledges and internal bureaucratic layers will be, participants remained wary of the current ability of Black and Brown people to utilize human resources for gaining equity. “You may not get a fair hearing or fair process when you speak up, as some human resource people are blind to some of these issues. [This] really makes it difficult for people to speak up.” “Many people in the big institution have a real fear of retaliation, and therefore speaking up and speaking out has been a problem for years.”

In the absence of a strong self-reliant movement by leading global health organizations, participants reflected on changes that they have witnessed or brought about by their own initiative. They spoke encouragingly about their own reflections of how they “had embodied racism”, but how it was possible “to take people on a journey and bring the organization along on that journey.” With the recognition that “changes are not comfortable, it is not easy”, participants expressed some hope that personal transformation and individual change, led by Black and Brown people in decision-making positions, can lead to incremental advances. “Organizations are made up of people. The CEO gets to decide who gets held accountable [and] can hold individuals in leadership positions accountable to create accountability mechanisms for the organization”. “It comes back to the question of leadership. If there is no receptive audience among leadership, individuals get punished. The leadership level has to be ready and not react defensive. I definitely feel defensive about leadership decisions, but having that kind of openness in leadership and willingness to be open and learn will go a long way”.

Diverse hiring was recognized as important. But at least as important is attention to governance and the composition of boards of directors at international organizations and donors. In a participants’ own words: “This is significant because those are the bodies that are in power and make decisions about hiring at the top. [About] who is then responsible for the human and financial resources that are at the disposal.” Concern was voiced about the observation that these people in positions of power are an overall small group with a tight network. Black and Brown professionals including at the leadership level encounter challenges to entering this level of hierarchy. They are not considered part of that circle and do not have the same reach. In addition, board selections are essentially opaque, but are in charge of hiring and firing the CEO, and the organization’s money “and that’s the whole board game”.

With the proliferation of DEI pledges, one participant asked “how can we deal with the tokenistic use of our presence and discourses by institutions?” and further added: “Only hiring or inviting Black and Brown people without changing the structure and the perspective doesn’t solve our problems.” An analogy may exist between other social movements and their recognition on an institutional level. For example, for people living with HIV, making the GIPA principles, aka the principle for the Greater Involvement of People with HIV/AIDS, a reality has “relied on strong networks of people living with HIV/AIDS making sure that tokenism was called out and challenged. And yet GIPA often was and sometimes still is tokenistic. Therefore, can individual hires and appointments even work independent of a social movement?”

“The need to generalize experience, often by white scholars, is hegemonizing knowledge and diverse experiences.”

~ knowledge and truth in the global health space ~

Some discussion centred about what counts as knowledge and truth in the global health space. Participants recognized that while research may physically happen in the Global South, “but we take it to the Global North. That’s where it gets written up and we even put it in the contract that we will take that knowledge from you.” The perception of what constitutes knowledge and who holds intellectual power was visible in the common global health language that participants flagged during the introductory brainstorming round. Often, the learning agenda in global health is set by Global North institutions, e.g. funders and universities. Indigenous knowledge is commonly overlooked or ignored, including in education and language. This thematic area merits further exploration.

“The entire ‘compliance’ framework is based on distrust of Black and Brown people”

~ funding and philanthropy ~

White supremacy and colonial thinking, the remnants of the colonial exploits of the past, echo in the current global health funding landscape. Participants described global health philanthropy and funding as funder-dominated as well as high-income country dominated. A call has emerged from some philanthropic practitioners to rethink philanthropy and to think about honest metrics for holding organizations accountable. Participants seconded this need, but remarked that this remains a challenge. Participants observed that “even the organizations that want to make a difference don’t know how to do it.” Given that funders have a lot of power that emanates from their ability to award or withhold grants, they also have the power to “put pressure on organizations on DEI. This will get the attention [...]. It is all about the money.”

Participants pointed to the personal cost and institutional cost of the persistent lack of diversity, e.g. in the turning away of talent. The result of this more broadly is the inability of global health funders and implementers to – in one participants’ words – “design and deliver programs that truly meet the needs of the people they are intended to serve and that are able to better the human condition.” Hoarding of intellectual and financial resources was called out as “a huge loss to the world” and participants pointed to personal pain from frustrated ambition and lack of opportunity.

¹⁰ See for example Villanueva, Edgar. Decolonizing Wealth. Indigenous Wisdom to Heal Divides and Restore Balance. Penguin Random House, 2018.

Challenges were also raised with regards to tokenism. Participants pointed to a common experience of “having people from the south perform [a specific role] and that is where your contribution should stop”. Some participants considered the engagement roles of people from the Global South akin to that of begging rather than valued contribution of expertise, and that in the practice of global health, we must pay attention to who is in charge of program strategy design, implementation, and evaluation as well as who is in charge of decision making. In other words, do the people in charge of programs have power over human and financial resources that actually meet the needs of the community they are serving?

This points toward our need to consider the source and flow of money in global health. Questions we must ask ourselves include where is the funding coming from? What is it used for and what is it not used for? Who manages the funds and who is accountable for the money? Commonly, donors in the Global North add many restrictions on what specifically funding can be used for. There is a certain mindset that makes the elaborate accountability frameworks we have in global health necessary. That is, the idea that funders cannot trust Black and Brown people to handle money. Therefore, funders feel the need “to channel it through compliance frameworks handled by mainly staff in Global North to police Black and Brown people who are their own staff”. This creates a problematic conundrum from an organization-internal and ideological point of view. If not for white supremacy, why does this level of distrust exist in the first place?

“I worry that it will get co-opted and eventually silenced by [white supremacy], too”

~ tokenism and the moment of wokeness ~

There was strong agreement that we are currently in a so-called moment of wokeness that initiatives need to seize upon. There is an advantage that derives from the fact that racism is a topic across the globe and across many different fields. Many academic institutions have convened conferences about decolonizing global health. Among participants, a strong concern existed that this focus would not last and that the decolonization and racism discourse would become another space taken over by privileged people that “don’t understand what decolonizing really means” and who bring no lived experience to the conversation.

2020 was experienced as a watershed moment. The field of global health practitioners and academics has been openly discussing and writing about racism in global health. There has been a flood of articles on decolonizing global health, humanitarian work, and international aid. Alongside the concern about co-option and tokenism, was worry that this discussion “is mainstream now, but will it change anything?” While there was recognition that more conferences and more publications might be necessary to help global health professionals in the Global North to open their eyes and join the conversation, the next question is already clear. “How do we move from rhetoric to action?”

**“This is not a binary situation;
we have to be careful and subtle”**

~ silencing and intersectionality ~

Several participants expressed that they had experience with having their views silenced. For some, this was a result of their intersectional identities, e.g. of being a Brown woman in a position of power. One recounted being told “you are rare as a Brown woman CEO.” One person expressed that this made more urgent the need for them to examine how they themselves “uphold and collude in the white supremacy framework.” They suggested reflecting on how one as an individual has supported and centred whiteness. To consider how communities that are neither Black nor white are not always part of the conversation. As one participant stated: “[I] have just re-read Audre Lorde’s 1979 speech “The Master’s House” [...] so much is still the same regarding inclusion and exclusion of Black and queer women too.” One participant raised a strong note of caution that identities are not binary, and that there needs to be more attention paid to the exclusion of those people in global health outside the gender binary.

**“We need to have more of these
discussions to dig deeper.”**

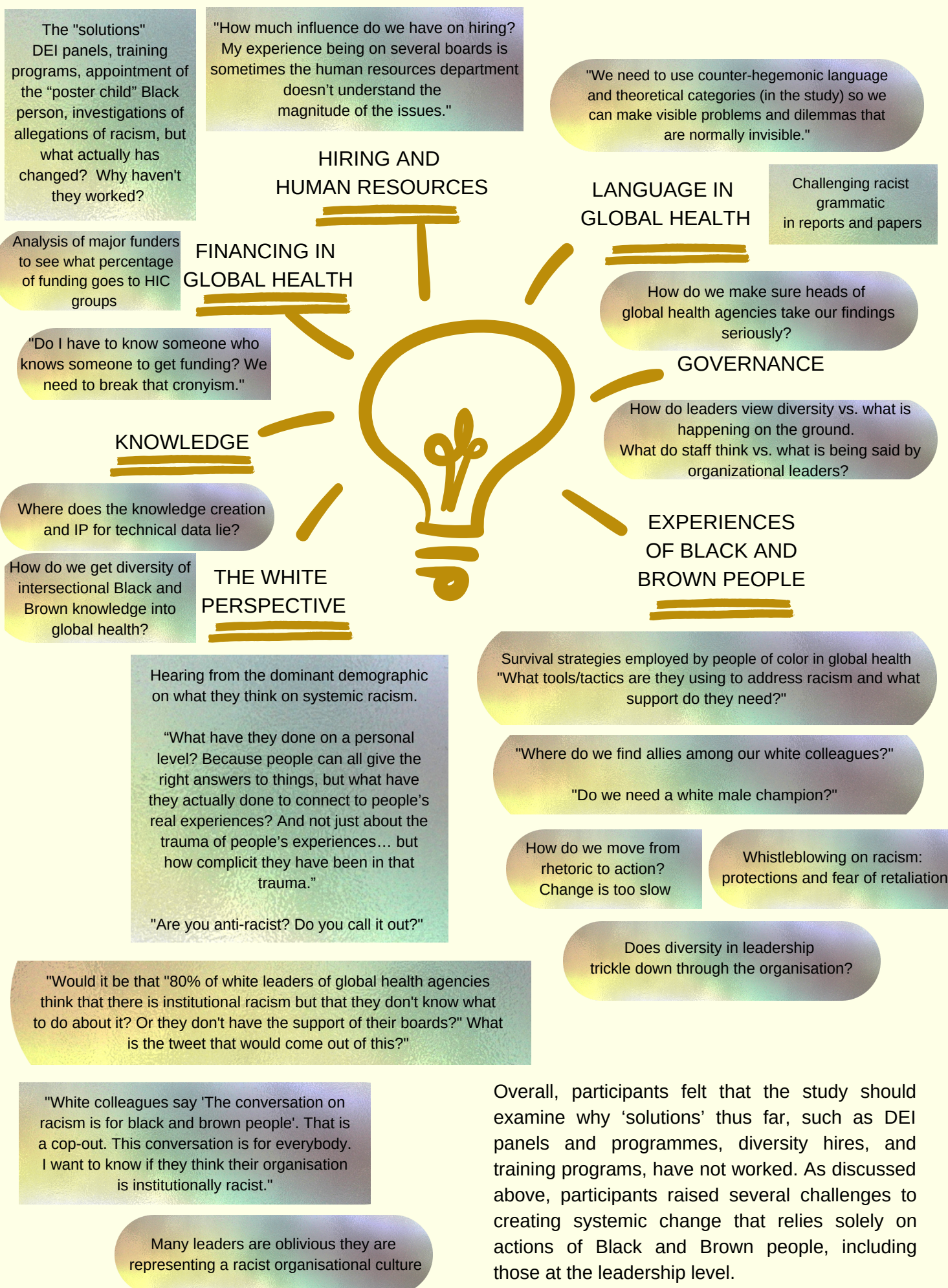
~ framing the conversation ~

The Roundtable was also intended to frame the research question, fine-tune methodology, and understand who the respondents should be. Our initial approach to the research was described to participants as follows:

An in-depth qualitative study to examine ‘what does racism look like in global health?’, conducted among 30 Black and Brown people working in global health, and key informants. The reason why we’ve included ‘key informants’ is because heads of diversity, equity, and inclusion of global health agencies could be white, and we’d like to hear from them.

Participants agreed that one of the important decisions that needed to derive from this conversation is how we frame this conversation and how we design the first research project.

During the Roundtable meeting, Participants were asked to make suggestions for research themes and concrete research questions. The following encapsulates the discussion:

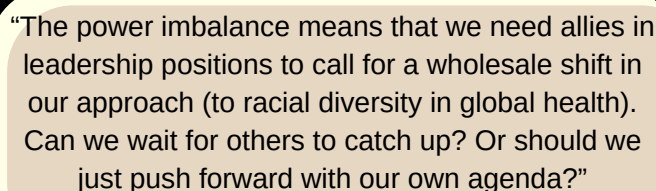


Overall, participants felt that the study should examine why 'solutions' thus far, such as DEI panels and programmes, diversity hires, and training programs, have not worked. As discussed above, participants raised several challenges to creating systemic change that relies solely on actions of Black and Brown people, including those at the leadership level.

The unrealistic expectation that one person alone can create change across a vast institution was embodied in the quote regarding the recent leadership addition at the WTO, i.e. that we need to move away from ‘the first’ and relying on them to move us forward. They may not be willing or not able to create systemic change. This unrealistic expectation also creates pressure and puts the burden on Black and Brown people alone. It is equally problematic that this expectation can quickly lead to tokenism, as pointed out in the discussion.

Furthermore, there was a lack of understanding on what white global health leaders thought of systemic racism and the anti-racist movement – did they think that institutional racism existed, but that they don’t know what to do about it? Did they not have the support of their boards? Or do they believe that institutional racism does not exist within their institutions? Participants throughout the discussion called for gaining a deeper understanding of white perspectives on the above discussed topics. It was also evident from discussions that Matahari and ARASA should not focus research on whether racism in global health existed – there is a wealth of evidence that it does and that it permeates all global health work. Instead, the research should focus on why interventions haven’t worked, what behaviour change is needed, and how stronger allyship can be built to move from anti-racist rhetoric into realistic action.

One participant said:



“The power imbalance means that we need allies in leadership positions to call for a wholesale shift in our approach (to racial diversity in global health). Can we wait for others to catch up? Or should we just push forward with our own agenda?”

The way forward from the study should include white allies on anti-racism in global health. And one way to do that was to examine what white leaders actually thought of institutional racism in their organisations and to ask Black and Brown people in their organisations about their experience of racism and allyship.

All of these issues raised in the two-hour Roundtable discussion merit further exploration and investigation. Practicality means that we need to focus our initial research and aspirations on developing actionable recommendations grounded in the experiences of Black and Brown people. Since the Roundtable, ARASA, Matahari and our research partner from Ezintsha at Wits University, discussed narrowing the research question and fine-tuning methodology, based on the above input. We agreed with participants that racism and white supremacy permeates every level of global health hiring, implementation, and governance. While the study should include the perspectives of white leaders, and should examine why interventions thus far haven’t worked, interviewing only white leaders of global health institutions would once again create a document written from the white perspective. This did not negate, however, the value of input of these white global health leaders. We agreed to limit interviews to three to five white leaders of global health agencies, with the remainder being Black and Brown people working throughout global health, including from within these agencies. Instead of the question “What does racism look like in global health”, we narrowed the research question to “Why are current interventions not working?” with a sub-question of “What behaviour changes are needed?” In addition to the in-depth interviews, we would run a brief SurveyMonkey questionnaire so that we could obtain data more widely - and Ezintsha would help with analysis of data from these surveys.

Conclusion and next steps

The Inception Roundtable and this resulting report are the first concrete steps in establishing this initiative on race in global health. For Matahari and ARASA, immediate next steps are:

- Establishing an Advisory Committee;
- Drafting the study protocol, questionnaires, and ethics approval (awaiting decision);
- Targeted dissemination of the report, including to white global health leaders;
- Building on the Inception Roundtable and continue building a vehicle for Black and Brown leadership;
- Fundraising – including for salaries, advocacy meetings, roundtables, and further research.

Advisory Committee

The three members of the Advisory Committee were announced on 26 April 2021. They are Dr. Stellah Bosire, the Co-Executive Director of UHA - The East African Sexual Health and Rights; Colleen Daniels, the Deputy Director and Public Health Lead at Harm Reduction International; and Prof. Luiz Carlos S. Faria Jr., Professor of International Public Law at the Pontifical Catholic University of Rio de Janeiro (PUC-Rio).

The Advisory Committee will provide accountability and strategic oversight to the initiative. Advisory Committee members will receive \$250 as honorarium. Roundtable invitees were invited to nominate themselves and other suitable candidates as Advisory Committee members with the deadline being extended to the end of March. Application requirements were a brief written expression of interest and CV, a letter of endorsement being optional. The selection was made by the project team. We envision four Advisory Committee meetings over the first year of the project with the first meeting scheduled for May.

Advisory Committee Responsibilities include:

- Providing input on project strategy;
- Reviewing written updates prior to Advisory Committee meetings;
- Attend Advisory Committee meetings, or provide feedback if unable to attend;
- Support project team in identifying fundraising prospects;
- Aid in circulation of inception report, research report and other written product resulting from the project;
- Media outreach and/or responding to media requests.

In the longer term, provided we can secure further funding, Matahari, ARASA, and partners based in the Global South will participate in targeted discussions with global health leaders on becoming allies in anti-racist global health policy as well as within their own institutions.

Research timeline

Ethics Submission

April 2021

Commence Interviews

July - August 2021

Analysis and Write-Up

August - September 2021

Dissemination and Advocacy

October - November 2021

Fundraising

The Racial Diversity in Global Health initiative was originally planned as a four-year project that includes qualitative and quantitative research. An initial grant of US\$50,000 has allowed ARASA and Matahari Global Solutions to begin with some qualitative research, scheduled for May through July 2021. The research analysis will inform a formal report and additional publications before the end of the year 2021. However, the project team is convinced that a larger scale study will add much value to the available knowledge and will help explore strategies currently being implemented to undress the lack of racial diversity in global health and inform solutions. As outlined above, Roundtable participants suggested many interlinked research areas that we hope to tackle through a variety of partnerships. The Project team is therefore continuing with fundraising in line with the initial vision of the initiative. Several participants on the roundtable volunteered to support fundraising and the project team has reached out to them to explore this further.

At time of writing this report, a further USD\$30,000 is needed to fund dissemination, advocacy, and research work for 2021.

Resources shared in Inception Roundtable

During and after the meeting participants generously shared the following resources with our team. These resources will form part of the initiative's literature review.

- Seye Abimbola et al. Addressing power asymmetries in global health: Imperatives in the wake of the COVID-19 pandemic. <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003604>. PLOS Medicine. 22 April 2021.
- Dr. Brené Brown. The Power of Vulnerability. https://www.ted.com/talks/brene_brown_the_power_of_vulnerability?language=en. TEDxHouston. June 2010.
- Amy Costello. What can we do about the white saviour complex? <https://nonprofitquarterly.org/what-can-we-do-about-the-white-savior-complex>. Non Profit Quarterly. 26 October 2018.
- Kimberlé Crenshaw. The Urgency of Intersectionality. https://www.ted.com/talks/kimberle_crenshaw_the_urgency_of_intersectionality. TEDWomen 2016. June 2016.
- Robin D'Angelo. White Fragility Part 1. <https://www.teachingwhilewhite.org/podcast/2018/8/18/white-fragility-part-one>. Teaching While White. 18 August 2018.
- Madelanne D'Rust Eye. The Roots of White Supremacy are in our bodies. <https://transitionnetwork.org/news-and-blog/roots-white-supremacy-bodies/>. 5 September 2017.
- Rae Johnson. Embodying Social Justice. Embodied Philosophy. <https://www.embodiedphilosophy.com/podcasts/rae-johnson-on-embodying-social-justice-85/>. 25 December 2018.
- Rae Johnson and Nkem Ndefo. When Agreement is not Consent. <https://medium.com/rae-x-nkem/when-agreement-is-not-consent-118e8d2f279e>. Medium. 26 January [].
- Kojo Koram (edt.). The War on Drugs and the Global Colour Line. <https://www.plutobooks.com/9780745338804/the-war-on-drugs-and-the-global-colour-line/>. Pluto Press. March 2019.
- Nkem Ndefo. On Trauma and Resilience. <https://open.spotify.com/episode/72MPsIIOfXKLXYesemz2Ci>. Embodied Philosophy. Episode #113. July 2020.
- Dr. Madhukar Pai. Men in Global Health, Time to Lean Out. <https://naturemicrobiologycommunity.nature.com/posts/men-in-global-health-time-to-lean-out>. Nature Portfolio, Microbiology. 19 November 2020.
- Psychedelic Seminars. History of the drug war, racism and colonization. <https://www.youtube.com/watch?v=eBf90gFz0PA>. YouTube. 21 June 2020.
- Layla F. Saad. Me and White Supremacy. Combat Racism, Change the World, and Become a Good Ancestor. <https://www.meandwhitesupremacybook.com/>. Sourcebooks 2020.
- Edgar Villanueva. Decolonizing Wealth. Indigenous Wisdom to Heal Divides and Restore Balance. <https://www.penguinrandomhouse.com/books/588996/decolonizing-wealth-by-edgar-villanueva/>. Penguin Random House. 16 October 2018.
- VPRO Documentary. The Post Racist Planet. <https://www.youtube.com/watch?v=jA4CcOvYMT4>. YouTube. 17 October 2020.

