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Transforming global health education during the COVID-19 era: perspectives from a transnational collective of global health students and recent graduates

Daniel W Krugman,[1] Malvikha Manoj,[2] Ghiwa Nassereddine,[3] Gabriela Cipriano,[4] Francesca Battelli,[5] Kimara Pillay,[6] Razan Othman,[7] Kristina Kim,[8] Siddharth Srivastava,[9] Victor A Lopez-Carmen,[10,11] Anpotowin Jensen,[12,13] Marina Schor [1]

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For numbered affiliations see end of article.

Correspondence to
Marina Schor; mschor1@jh.edu

ABSTRACT

Inspired by the 2021 BMJ Global Health Editorial by Atkins *et al* on global health (GH) teaching during the COVID-19 pandemic, a group of GH students and recent graduates from around the world convened to discuss our experiences in GH education during multiple global crises. Through weekly meetings over the course of several months, we reflected on the impact the COVID-19 pandemic and broader systemic inequities and injustices in GH education and practice have had on us over the past 2 years. Despite our geographical and disciplinary diversity, our collective experience suggests that while the pandemic provided an opportunity for changing GH education, that opportunity was not seized by most of our institutions. In light of the mounting health crises that loom over our generation, emerging GH professionals have a unique role in critiquing, deconstructing and reconstructing GH education to better address the needs of our time. By using our experiences learning GH during the pandemic as an entry point, and by using this collective as an incubator for dialogue and re-imagination, we offer our insights outlining successes and barriers we have faced with GH and its education and training. Furthermore, we identify autonomous collectives as a potential viable alternative to encourage pluriversality of knowledge and action systems and to move beyond Western universalism that frames most of traditional academia.

SUMMARY BOX

- ⇒ The curricular content of global health education (GHE) did not sufficiently and holistically incorporate the teachings from the pandemic regarding global health's perpetuation of the current global ordering and power asymmetries, and critical perspectives, such as those of Indigenous peoples, remained missing from fundamental discussions.
- ⇒ Positive changes in global health curricula in response to calls for reform seem to be predominantly the result of individual or small groups of action-oriented educators and students willing to commit to adapting their courses to ensure a foundation in justice, equity, antiracism, decolonisation and anti-oppression.
- ⇒ The shift to online learning provided GHE the opportunity to become more 'globalised' and explore new models to redistribute power and provide a voice to those traditionally marginalised within knowledge systems through increased transnational collaborations and the inclusion of diverse perspectives, knowledge and expertise beyond the characteristically dominant high-income country-based male voices.
- ⇒ Most institutions have turned to diversity, equity and inclusion committees and strategies to address issues with the current global ordering; however, collective members reported that such initiatives often entailed practices that felt 'safe' to universities and that did not allow for meaningful structural change, doing little to affect-related policy and systemic environments.
- ⇒ Student-led organising beyond the classroom environment, with the inclusion of educators and based on solidarity, are an important path forward in the process of GHE change given their ability to connect individuals from across institutional, nation-state and disciplinary divides to partake in co-generative learning and action towards a common goal.

INTRODUCTION

The COVID-19 pandemic revealed several fault lines in global public health[1–6] and has spurred calls to reconsider the modus operandi for its education and practice.[7–9] Inspired by the 2021 BMJ Global Health Editorial by Atkins *et al*, a group of students and recent graduates of disciplines across global health (GH) convened to form a transnational collective to discuss global health education (GHE).[7]

As Atkins *et al* outline, the pandemic can be a teachable moment to re-imagine and re-orient the focus of GHE on equity, justice and human rights while rethinking how

to effectively armour trainees with the skills needed to improve health in their communities.[7] Our collective experience suggests this window of opportunity remains to be fully seized. While our experiences varied depending on topics, contexts and institutions, it was clear through our discussions that power asymmetries often underlie our education. Furthermore, we saw that despite best intentions in the face of glaring gaps in access, environment, content and delivery,[10–13] the GHE industry remained wanting, and institutions and their GH-affiliated programmes displayed varying levels of resistance and receptivity to needed changes. Put simply, global public health and its education continue to maintain a dysfunctional status quo in many ways, making discussions and actions to explore and implement alternate ideas around its learning and practice imperative.

This commentary aims to synthesise the experiences of this collective with GHE during the pandemic, explore the successes and barriers we faced in engaging with and re-imagining GHE and identify autonomous collectives or affinity groups between students, educators and others as a potential tool to transform GHE within and beyond traditional knowledge systems. At this moment when threats to people's health are dramatically increasing due to a prolonged pandemic, rising climate catastrophe and increasingly prevalent fascist movements,[14 15] the window to improve people's health is closing. For GH to live up to its name, we must change how we educate and train future practitioners and leaders. Our experiences over the past three years have raised an unequivocal and urgent call for action.

We acknowledge that this group does not capture the full spectrum of experiences that GH students have been facing during the pandemic. Rather, this commentary serves as a window to a collection of student experiences that can be used to inspire further dialogue and action to transform GHE.

A TRANSNATIONAL COLLECTIVE FOR UPROOTING GLOBAL HEALTH EDUCATION

The current paradigms and practices of research in GH academia are often limited by design in their ability to promote community organising and bottom-up transfer of knowledge to address global public health challenges.[16] Thereby, this alternate space for students and recent graduates was envisioned by two coauthors (MS and DWK) building on various youth-led and student-led efforts within and beyond GH that work towards systemic transformation (see box 1). Within the bounds of efforts to change GH, we continue the critique emerging from various initiatives, such as to 'decolonise' curricula and address institutional racism at the University of Cape Town which then sparked similar movements in academic institutions teaching GH, primarily in the Global North.[17–24] Inspired by the work of Koum Besson *et al*,[23 25] the collective's ethos focuses on 'undoing, unlearning, redoing and relearning' to encourage a shift towards GHE that is centred on contextuality, collective learning, decentralisation and resistance to systems that maintain injustice and inequities.

GLOBAL HEALTH EDUCATION DURING THE COVID-19 ERA

Global health governance, leadership, funding mechanisms, prioritisation processes, knowledge generation and sharing and by extension, GHE and training across most contexts have remained largely shaped by a Euro-American and North-American centric global ordering.[8 26 27] GH been rooted in coloniality, with the exception of a few, such as Indigenous peoples from Indigenous Nations within Global North countries.[28] This asymmetry manifests in *where* much of GH practice and education happens, *what* is recognised, championed and taught through core curricula and *how* power sustains Western universalism in GH.[13 29 30] A 2020 analysis of GH programmes revealed that approximately 88% of programmes were located in North America and Europe, compared with just 1% in Africa.[13] Moreover, current curricula in many such programmes minimally explore the colonial origins of GH, are largely presented as 'apolitical', and rarely inspire appropriate action against forms of oppression, such as structural and interpersonal racism.[9] Furthermore, institutions have failed, and continue to fail, to recognise Indigenous Nation's and Indigenous peoples' rights. While the past few years have seen an increase in the *quantity of* discussions and conversations around the colonial origins and its remnants in GH, the *quality of* such engagement remain questionable, and are often siloed, suppressed or exclusionary, for example, even North America's Indigenous peoples remain excluded in decolonisation conversations which are inherently about and should be for them. While GH scholarships and fellowships have been instrumental in training a growing cadre of health professionals, they are also an imperfect solution to create a *globally* representative workforce, especially as the education thus accessed is often grounded in Western epistemic power, systems, attitudes and value systems.

This baseline of GHE has now been compounded by the COVID-19 pandemic for three school years, and continues to be so.[31–35] Against this backdrop, we find that we are at a critical juncture. Recognising that the modus operandi for GHE must change, we explore our experiences through the shared understandings that the pandemic can be a window of opportunity to review the different impacts COVID-19 has had on the next generation of GH professionals and to leverage these insights to course correct, *now*.

Institutional adaptation to the pandemic

The pandemic has disrupted access to and quality of education worldwide, with great variability in the ways academic institutions responded and the accommodations they were and are able or willing to provide students and faculty.[36 37] It is imperative to situate that many of

Box 1 Formation and functioning of this transnational collective

Formation:

The conceptualisation of this group and the principles it organises around are drawn from historic and current multimodal efforts to effect change inside formal structures and institutions through organising outside and between those structures. Inspired by movements such as 'ACT UP' during the HIV/AIDS crisis,[80] 'Extinction Rebellion' currently fighting global climate collapse,[81] Greece's Coalition of Radical Left 'SYRIZA'[82] and 'La Via Campesina' internationally,[83] MS and DWK imagined this collective as one that seeks to create space outside power-holding institutions.

By nurturing community and collaboration between disciplines, geography, gender, cultural background, etc, this collective aims to create space for both new knowledge to emerge and for the means to push powers (in this case, global health education (GHE) industry actors) to react to that knowledge. Following the principles of 'transnational autonomous organising' summarised by Graeber[71] and Affinity Groups[72] such as Voltairine de Cleyre,[73] Rama and Cappelletti,[74] Dupuy[75] and Roda,[76] this group is conceptualised as an 'autonomous transnational collective' or 'affinity group'—a small cell of people created beyond the scope of formal institutions for a specific project of changing those formal structures.[71]

Thus, this group can be seen as similar to student and civil society organisations like International Federation of Shipmasters' Associations, International Veterinary Students' Association, International Political Science Association, Universities Allied for Essential Medicines[84–87] that have been organising emerging professionals that facilitate peer-to-peer learning on topics under-represented in traditional curricula while actively working with and outside academic institutions to change curricula long before the pandemic began. However, following previous collectives'[80–83] commitment to informality and resistive politics, we differ from these organisations in the politics and theoretical principles we employ both in the conceptualisation of this collective and the actions it seeks to take (see box 2).

Process:

This collective was formed when a group of students and recent graduates from around the world convened to discuss GHE. Senior academics focused on equitable global health scholarship were contacted by MS and DWK through a snowball process which helped identify students worldwide to join this effort. The backgrounds and educational experiences of the individuals who form this collective cover a wide range of geographies, genders and disciplines.

While the collective originally organised to discuss and synthesise learnings and insights from our experiences in GHE and practice during the initial stages of the COVID-19 pandemic, our scope expanded to discuss the transformation of GHE itself. The group convened every week at two different times to accommodate students in different time zones. Weekly meeting agendas varied, but generally focused on (1) understanding what 'global health' meant to the members of the collective, (2) discussing different experiences in GHE, (3) exploring student reflections around representation and/or exclusion within their institutions, (4) discussing the emergence and impact of 'decolonising global health' movements and (5) understanding how student-led organising can be a tool towards equitable GHE.

Meetings were held over Zoom and recorded and stored along with meeting notes in a shared folder for future access. Suggested discussion questions for each week were set at the start by MS and DWK to provide initial structure, partly inspired by Atkins *et al*.[7] As the collective evolved, agendas were predominantly set through self-determination of the group as a whole.

Demographics:

The collective brings perspectives from an internationally diverse group of students and recent graduates from a wide range of cultural backgrounds. Of the overall collective, a subset of members are coauthors of this paper, and their demographic information is provided here.

The coauthors represented come from the following home countries: Brazil, India, Indonesia, Lebanon, Peru, South Africa, Sudan, the United Arab Emirates and the USA. However, multiple coauthors live or study in countries different from the country of their nationality. Thus, our educational experiences further span the world, and we have members who have studied in each of the following places: Australia, Canada, Lebanon, India, Peru, Sudan, the UK and the USA. Furthermore, some of us come from Indigenous Nations within Global North countries, namely the Oglala Lakota Nation, Hunkpati Dakota Nation and Yaqui Nation in the USA. We also aggregate proficiency in a number of different languages including Arabic, Chinese, English, French, Hindi, Indonesian, Italian, Malayalam, Mandarin, Pashto, Persian, Portuguese, Spanish, Swahili, Urdu and Lakota. Lastly, the current gender breakdown of our collective is 74.9% female, 18.8% male and 6.3% gender non-conforming, all of which combined allow us a diverse range of voices which inform this commentary.

It is important to note that the first and last authors of this paper both attend elite global health institutions in the Global North. This inherently influences the scope of their knowledge and ability to effect change. Yet, given that the GHE industry and affiliated global health programmes still remains most pronounced (~88%) in the Global North,[13] this may say more about the geographical accessibility of GHE, than about the representativeness of the lead authors in contributing to this article. Beyond representation politics, the politics of these authors—one of whom is a queer Brazilian who leads the antipolicing initiative at said school and the other who is a Baltimorean anthropologist involved in abolitionist, harm reduction and mutual aid organising—merit being held distinct from the institutions they have chosen to attend. Of note is that this choice, especially for those in the Global South, is guided by the global asymmetries which this commentary speaks to, given that the current distribution of power in the world dictates which knowledge is valued. Another recurring point for our collective was that someone who attends an institution in the Global North will inherently have access to more opportunities than those who attend Global South institutions—this will be further explored in this commentary. Lastly, the goal of both of these authors was to bring together individuals from different backgrounds from around the world to represent their experiences in GHE, despite the authors' positions at high-income country institutions.

these experiences are not exclusive to students of GH. Yet, they are worth exploring within the scope of GHE as they are indicative of how wider global ordering and processes manifest to affect public health trainees and their experiences of the systems they ultimately influence. If equity and justice are central to achieving global 'health', should not the GHE industry model these ideals in how it organises and conducts itself?

Across this collective, members felt that accommodations to support student and faculty safety and well-being

to adapt to the COVID-19 era (where any were available) were often severely lacking, with significant impact on their physical and mental health. Many students felt as though they had to choose between preserving their health and obtaining their education. Indigenous students felt that they had to unfairly make a choice between their education and kinship vital to the survival of their culture and well-being. Furthermore, one of the coauthors recollected that, in the later stages of the pandemic, their university refused to accommodate students who were unable to attend class in-person despite COVID-19 spikes nationwide, instead suggesting that these students take a leave of absence or withdraw from the university entirely. Other institutions continued education without mask mandates or COVID-19 vaccine requirements, despite formal labour complaints by faculty members.[38 39] Frontline healthcare students reported feeling unsafe and afraid to pursue their medical duties, tasks and curricular activities without access to COVID-19 vaccines and adequate protective measures.[40 41] Indigenous students felt the dual-burdens of cultural responsibilities at home, such as helping with childcare and going to ceremonies, while attending school virtually, often without accommodations for these cultural obligations.

The shift to virtual learning also imposed barriers on many students and educators who live in areas without adequate tools, such as stable internet or electricity, or who are unfamiliar with emerging technology. For example, Indigenous students that lived on Reservations faced limited access to Wi-Fi as well little to no access to water. While some of these access issues could have been addressed by academic institutions, they consistently were not.

Moreover, because of continuously changing immigration policies and border closures caused by rising COVID-19 numbers and geopolitical power plays, international students were often stranded in their country of study or forced to relocate. In other cases, the pandemic combined with other crises—such as civil unrest, financial collapse and war—deepened the already existing educational divide among students, which also manifested in GHE. While some of these challenges went beyond adaptive capacity or control of academic institutions themselves, they illustrate the impact of complex geopolitical tensions and the politics of GH on access and quality of GHE and training.[42 43] Evidently, the disruptions to learning caused by the COVID-19 pandemic do not exist in isolation and one must systematically consider all the factors at play. For existing inequities, the pandemic further exacerbated the issues at hand and demonstrates the necessity of addressing systemic issues within Rreservation borders or within the bounds of sovereign Indigenous Nationhood.

Overall, the conditions members of the group learnt in were dictated by the diversity of tactics their institutions and their nation-states of learning employed to mitigate the pandemic and other crises that evolved over the past 2 years.

Global health education: content and delivery

Although the pandemic emerged as a great example of how local and global social, commercial and political determinants of health drive the practice of public health, several members of this collective felt that the content and delivery of GHE across many institutions had limited success in leveraging external events for internal transformation. By this, we mean that for many members, GHE continued to be largely focused on health 'somewhere else', 'for someone else' and was predominantly anthropocentric, even as local and planetary health challenges became increasingly severe.[44] The pandemic clearly demonstrated that mortality and morbidity of public health priorities (including, but not limited to the opioid epidemic,[45] housing crisis,[46] poverty and hunger prevalence,[47–49] mental health crisis[50 51] and climate disasters[52 53]) are exacerbated by the way in which local contexts are influenced by the current global order (ie, power localised in high-income countries (HICs)) and systems. However, even with the inequity of the world, the focus of many programmes did not evolve to armour us with the knowledge, appetite and/or skills for bottom-up, cross-sectoral, transdisciplinary, community-informed and policy-dynamic that we recognised as critical for positive action beyond the confines of our classrooms. Furthermore, institutions failed, and continue to fail, to recognise Indigenous Nation's and Indigenous peoples' rights and to meaningfully incorporate Indigenous peoples' perspectives and voices into conversations and decision-making processes within the organisations.

Curricula, fieldwork and dissertations in institutions in the Global North still focus largely on public health crises in the Global South. Furthermore, much of the GHE in the Global South aligns (or is made to align) with the epistemic, financial and political powers exerted by institutions in the Global North, whether through 'global' standards and frameworks, financial purse strings attached with grants and partnerships or through affiliate-institutions that remain devout to the vision of HIC-based parent institutions. While the incorporation of concepts like equity, justice and oppression into GHE introduced many students into discussions or ideas they did not engage with previously, several students shared that these discussions remained limited to one-off conceptual references in 'special lectures' or occasional facilitated dialogue, rather than being weaved into overall GHE course narratives as essential, critical components, which they would have preferred. Often, these discussions also emerged parallel to broader global or national events that threatened equity and justice. Many students described wanting to explore them further in-depth, hoping for a focus on how these concepts can be applied to the praxis and value systems of GH professions locally and globally. Indigenous students explained how they saw the use of the term 'decolonise global health' increase in Global North countries during the pandemic, without true engagement and creation of a seat at the decision-making table

for members of Indigenous Nations within Global North countries that still suffer the health impacts of colonisation. Various coauthors described feeling as though there was either institutional lack of knowledge and/or awareness, unwillingness, discomfort or at times downright denial and resistance among some educators and colleagues to integrate these topics into their curricula. We encourage candid discussions between GHE institutions, educators and students to explore these tensions further, in an attempt to reimagine GHE to cater to the interests and needs of emerging GH professionals.

Compelling and hopeful exceptions to these trends emerged through the stories of some members, who recounted instances where action-oriented faculty made more structural adaptations to courses. One member highlighted a political analysis of public health course where faculty used various local and global examples to explore how power and privilege manifested throughout the pandemic and incorporated weekly news and headlines that linked to health policy analyses. Another member pointed to a faculty that fundamentally changed the curricula to centre the voices of those traditionally marginalised in global public health discussions. An Indigenous author noted how when their university medical schools partnered with the Oglala Lakota Nation, the author presented a cultural competency training in hopes to prepare the physicians. This helped provide historical context, elevate Indigenous voices and promoted Indigenous-led partnerships, and not just tokenism. From group discussions, it became clear that positive changes in GH curricula in response to calls for reform seemed to be predominantly the result of individual or small groups of action-orientated educators and students willing to commit their time and (unpaid) labour into adapting their courses to ensure a foundation in justice, equity, antiracism, decolonisation and anti-oppression. Systemic and systematic adaptations to GH teaching remain to be fulfilled.

Furthermore, although the shift to virtual learning was accompanied by various challenges, it also provided new opportunities for transnational collaborations and the inclusion of diverse perspectives, knowledge and expertise beyond the dominant HIC-based male voices.[54] Guest lectures and collaborative discussions included diverse faculty and students across geographical, professional, disciplinary and demographic backgrounds—including those in close proximity to the issues being taught. GHE thus became more 'globalised' in some instances and explored new models to redistribute power and provide a voice to those traditionally marginalised within knowledge systems. These efforts were deemed most effective by coauthors when they addressed inequities in opportunity. For some, education also became more interactive during virtual learning, with increased group discussions and collaboration. Yet, in other instances, a lack of online engagement resulted in a lost sense of social connectedness and belonging prompted by continued social isolation.

Several coauthors reported a change in exam structure from solely memorisation-based questions to those that required more critical thinking. Grading systems were also altered in some institutions to accommodate distance learning. Students mentioned that these changes often increased learning transparency, fairness and consistency. However, such positive impacts were not universally experienced, once again highlighting inequities, with those in higher socio-economic strata often benefiting more from the adaptations compared with other students.[55 56]

Furthermore, as in-person connection became restricted, virtual connection in informal settings (such as Twitter, Slack, Zoom, etc) became increasingly important. Many members cited that they learned about different ideas about GH such as 'decolonisation' from Twitter or informal chats. However, many such discussions and formal conferences, panels, etc remain primarily entrenched in HIC-based networks and circles. Thus, while the locus of power has shifted in some ways, it continues to remain embedded in predominantly elite networks. Another member whose education had been disrupted by both the pandemic and another compounding crisis stated that they learned about GH almost completely outside formal institutions. This group, and others like it, took on new importance because of the conditions of the pandemic. Democratising GHE and facilitating meaningful cross-boundary experiences have ways to go. Yet, change seems possible and pressing.

These positive examples are indeed cause for hope, as they signal that *there are ideas and efforts* that have demonstrated initial success in making GHE more accessible and relevant to trainees. It also highlights that the absorptive capacity of the GHE industry to scale such efforts needs to urgently increase, so that examples like those mentioned above are not the product of solely individual motivated efforts but can include an overall systematic and systemic effort to re-imagine GH.

Receptivity and resistance to change in global health education and training

Below, we outline some of our experiences engaging with institutional receptivity and resistance to change in GHE. As stated earlier, most examples of receptivity from within institutions came from individually motivated educators and students rallying together to advocate for and push forward dialogue and action around GH transformation.

Across several HIC contexts, the resurgence of the Black Lives Matter movement in 2020 was an important catalyst for a series of critical discussions on change within GH (and to a certain extent in some low-income and middle-income countries (LMICs)).[57 58] For instance, while not universally applied, much of the institutional response to police brutality in the USA took the form of diversity, equity and inclusion (DEI) initiatives, or other formal or informal groups of students and educators focused on adapting and transforming curricula to address gaps laid bare by such global and national events. However, in several institutions where students within this collective

engaged directly with such efforts, collective members reported that such initiatives often entailed practices that felt 'safe' to universities and that did not allow for meaningful structural change, doing little to change-related policy and systemic environments. Despite countless meetings with deans, DEI working groups and antiracist, anticasteist, antisexist (etc) and/or decolonial curriculum development, some group members found limited investment and prioritisation to expand action beyond the maintenance of the status quo. Several students and select faculty were dealing with the responsibility of initiating discussion and redesigning curricula while juggling full-time education, research and/or clinical placement. Paradoxically, while students and staff were stimulated to generate these deliverables, they were often met with 'soft' and/or 'hard' institutional pushback when the content was considered 'too radical' or, more specifically, when the changes proposed necessitated fundamental shifts in how power permeated across the institution's funding, hiring, teaching and/or outreach activities. For example, one student advocating for integrating concepts around decolonisation and racism into their Global North-based institution was met with denial from the director of the programme, responding that their statement, 'Global health is rooted in a colonial and racist past' was too 'harsh,' and that there was not evidence to support this claim. Indigenous students attempting to integrate the importance of Global North countries returning land to Indigenous Nations to improve Indigenous health were told not to use the term 'stolen land'.

While a couple of coauthors reported discussions within LMIC-based institutions around the colonial and discriminatory roots around health(care), most coauthors reported that they would have liked to have explored these topics more deeply, especially in the context of how these roots manifested in their present day lived experiences and the enablers and barriers that facilitate their career trajectory. Many reported turning to social media, other formal and informal groups and collectives, global shifts and local movements and events to get information on such topics. Several coauthors reported local and national movements that shaped the state of health of their communities more broadly, yet these did not always permeate GHE circles and institutions.[59–62] At this point, we cannot fully capture why that might be. Against this backdrop, stories of institutional receptivity also emerged: one of the coauthors reported that antimilitary protests and consecutive coups in their country inspired several medical and global/public health institutions to renew and reconsider their accreditation process, an exercise initiated to critically review current curricula, tools and student engagement policies at these schools. Another coauthor reported that anti-coup protests in their country[63] sparked discussions in academic spaces to strive for education to be inclusive, local and culturally respecting. For one such coauthor, this propagated the creation of a new curriculum led by students in collaboration with faculty in their institution.

In several cases, coauthors noted that even with the best intentions, some efforts fell short, either in investment, content, delivery, institutional knowledge or buy-in from those with the power to exert change, among other reasons. To expand, some coauthors who directly engaged with GHE advocacy efforts in their institutions mentioned that institutional efforts felt 'superficial' at times, as for example, institutional leadership did not go beyond media releases, statements, special committees with limited power to materialise change or one-off special lectures or panels in an attempt to address complex, nuanced and contextualised issues. Another student reported that spaces for discussions around colonialism and power discrimination were largely missing from their Global South-based institutions, especially given disruptions due to the pandemic. This limited pertinent discussions around broader global and local issues outside of a predetermined curricula that skewed the view of GH through the lens of the biomedical paradigm.

A few coauthors even noted that they, along with other motivated students and faculty, experienced outright 'resistance', 'dismissal' or 'silencing' when critiques of institution-led and/or faculty-led mission-unaligned actions were raised. The latter point is especially crucial: how are motivated faculty and students expected to continue to push for change when they exist within complex microlevel political contexts that threaten their very progress and survival in this field? This becomes even more salient when recognising the power difference between, for example, a tenure track professor advocating for radical change, and a first-year masters student echoing the same.

Importantly, the combination of bearing the responsibility of encouraging improvements within their GHE, full-time studies, institutional pushback and an impossible threshold for activation energy resulted in negative mental health and burnout among many involved. A few members inside the group stated that they have considered leaving their institution, and GH altogether. Furthermore, burden for change often disproportionately fell onto students and educators that were from historically marginalised and oppressed communities, some of whom struggled with accessibility and affordability of such institutions in the first place.

Yet, many coauthors continue to push for the GHE industry to 'walk the walk' in terms of fundamentally incorporating justice and equity into its structures and practices. This can be done, for example, by investing—financially, with human resources, energy, or time—in strengthening specific policies, actions, mechanisms and ultimately the structural environments needed to transform GHE. Such investment is not exclusive to HIC or LMIC institutions—it takes all, across all levels of the GHE industry. LMIC governments, donors and actors need to invest in strengthening the locus of epistemic power in LMICs; invest in and increase the number of quality, accredited and globally visible GH programmes; invest in the educational workforce and more. Similarly, HIC

Box 2 Core theoretical principles that grounded the forming of this collective

While our own collective has benefited from identifying itself as an autonomous collective guided by core principles outlined by David Graeber's anthology on direct action which summarises the work of many others,[71–76] we do not mean to prescribe our methods as the catch-all solution for transforming global health, or for organising for global health. Instead, we encourage a plurality of solutions and ideas around how various actors can unite to reimagine and reconstruct global health, even beyond the ideas shared here.

Furthermore, we recognise that there is no 'right' way to form or conduct an autonomous collective. It may constitute any group of people. They may be raised by an individual with an idea, or a group of people brought together by some circumstance. They may exist for a short period of time for a specific purpose or grow into massive organisations. An 'autonomous collective' or an 'affinity group' is one where every member is there by choice, the group is unattached to an institution, and the group is created for a purpose.[68] The beauty of framing them as such is that it is anything that the group makes it to be, and each one will be unique.

Recognising and establishing this, we outline the principles that shaped the formation of our *own* collective as a part of the pluriverse of ideas and actions towards global health transformation.

1. **Creating prefigurative structures**
   - While transinstitutional and transnational collectives currently hold very little power, authority and status compared with traditional academic institutions, this does not prevent them *from becoming* an institutionalised, legitimate form of education in the future. Informal collectives are often where (un)learning occurs and new ideas form without the direct influence of traditional powers. They are creating the space and structures for *rehearsing* the methods for a global health education yet to come.
2. **Seeking to unify means and ends**
   - The end goal is not the reform of educational institutions through recommendations or checklists, but the building of power of emerging structures that counter the legitimacy and perceived usefulness of currently powerful institutions (this building of power may lead institutions to transform themselves). Thereby, the formation, maintenance and growth of the collective is both the *means* of creating change and the *end* goal of that change.
3. **Resisting oppressive structures through education, organising and direct action**
   - A collective can never exist in isolation or be apolitical. Whether acknowledged or not, every affinity group is grounded in and guided by a political orientation. Thus, to move towards enacting meaningful change in global health education and the field at large, engagement with theory resistive to the status quo is imperative. This resistance is often jointly learnt inside this collective space, and as it moves beyond its bounds and becomes demonstrated outside the collective or affinity group itself, it harnesses power. This further movement could be anything from taking part in larger antiracist, anti-oppressive, decolonial protests and direct actions, to public writing.
4. **Practising communal care**
   - Organising is a process of healing that can help support mental health maintenance.[88] In this challenging era of pandemic, climate catastrophe, and war, on top of the individual stress and anxiety caused by academic institutions and global health labour, spaces of solidarity and care are needed. A collective can be *a space of safety, healing, venting* and *support* as much as it is about resistance or education. Whether constituted by neighbours or individuals scattered across the world, the collective presents an opportunity to practice mutual aid through redistributing resources, advocating for the needs of members or standing in solidarity with a member's call to action.

institutions professing commitments to DEI and justice need to fundamentally reimagine the who, what, why and how of institutional leadership, faculty, students and the enabling environment required to set up students for success. Furthermore, several members expressed that intentions or more specifically, commitments made by national, institutional and/or faculty leadership must have mandatory accountability and monitoring mechanisms associated with it, with other ideas including for such efforts to be co-chaired or co-led by representative and democratically elected student-faculty-leadership teams *with the ability to exert power when actions do not match intentions*.

The pandemic has lifted a smokescreen in GH practice, calling into question various aspects of its existence and praxis. In light of this, we put forth the following questions: How can the global health model achieve its necessary impacts if the field and its training remain embedded within an unequal and unjust global ordering that inhibits many, and frees a few? Are there ways to reconstruct GHE to be more transformative? For our collective, the answer to the latter question included complex multimodal answers, which ultimately tilted in favour of hope. The next section explores our reflections on one potential way to transform the current dominant mode of GHE delivery and engagement.

MOVEMENT TOWARDS A NEW GLOBAL HEALTH EDUCATION

Dissent for change, especially from your people, has always been present.[2–4 23 25 64–68] As Libola Hirsch makes clear: we will not 'achieve structural change while seeking progressive reform and working through channels that were set up within structures that uphold White supremacy'.[16] Ideas and recommendations concerning how to change GH,[23 68] or what the components of a different GHE[25 69 70] could look like exist and have been widely circulated. In this time of urgency, the transformation of education within classrooms needs to be supplemented by leveraging the agency of students and educators to create autonomous collectives and organise beyond classrooms. The collectives like this that have existed and currently exist both represent a different way to acquire knowledge and a means for transforming

GHE. While acknowledging that access to such collectives still has ways to go in many instances, we believe that by creating local and/or cross-regional affinity groups and collectives, students, practitioners and educators can convene to create pluriversality of knowledge and action systems, and move beyond Western universalism that frames traditional academia.[29] Such spaces can offer an alternative way to unlearn, relearn and continuously learn, while engaging with critical theory and methods of resistance that lie beyond institutional knowledge systems.

Thus, this collective calls for organising and action beyond traditional classroom settings and academic modalities through a plethora of methods. By organising collectives, we mean the conceiving and congregating of students (and educators) from across institutional, nation-state and disciplinary divides to partake in co-generative learning and action towards specific projects of change. These are typically not policy creation groups or professional organisations connected to structures of power. Rather, they are collectives of communities that take power over knowledge creation, education and conversation for themselves to reimagine and adopt new or alternative ways of learning, knowing and doing. In this way, they build pressure and power from the 'bottom', which ultimately has the potential to change the 'top'. Box 2 outlines the core theoretical principles drawn from Graeber,[71] Affinity Groups[72] such as Voltairine de Cleyre,[73] Rama and Cappelletti,[74] Dupuy[75] and Roda[76] that helped conceptualise the creation of our collective, in the hopes that it inspires dialogue and action beyond our group. It must be acknowledged, though, that different students and educators have unequal levels of agency and ability to participate in these activities, and approaches to democratise and diversify the existence of such collectives to be more accessible, available and engageable, are critical to its sustainability. Historically, for example, those involved in women's liberation movements[77] differed in how much they could participate, which was largely dictated by race. Radical solidarity[78 79] between those involved was instrumental to overcome barriers to entering and participating in such environments to shape their praxis allowing it to serve all. Today, solidarity remains at the root of what is needed for the success of collectives as a way forward in changing GHE.

GH pedagogy cannot continue to cater to inherently discriminatory structures and systems established through historic and remnant violence. At this moment, emerging public health professionals are facing pressure from everywhere, across local and global crises, that will fundamentally test the future and sustainability of our planet. With this pressure also comes the possibility of radical transformation and the ability to reimagine a world order that does work for all. For us to appropriately respond and organise around addressing these crises, we require a GHE system that can armour us effectively. We are not there yet, but change is possible. Actively advocating for change within classrooms can and needs to be supplemented with organising beyond classrooms to lean into our own power over process. An actively anticolonial, anti-imperial and anti-oppressive GHE can be achieved, and this requires a collective that is united in solidarity to work towards justice, equity and freedom.

Author affiliations
[1]International Health, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA
[2]International Working Group (IWG) for Health Systems Strengthening, Dubai, UAE
[3]International Working Group (IWG) for Health Systems Strengthening, Beirut, Lebanon
[4]Faculty of Medicine, Cayetano Heredia University, Lima, Peru
[5]Department of Microbiology and Immunology, McGill University, Montreal, Quebec, Canada
[6]Sydney School of Public Health, The University of Sydney, Sydney, New South Wales, Australia
[7]Faculty of Medicine, The National Ribat University, Khartoum, Sudan
[8]Global Health Policy Unit, The University of Edinburgh, Edinburgh, UK
[9]The George Institute for Global Health India, New Delhi, Delhi, India
[10]Hunkpati Dakota Nation, Oceti Sakowin Land, Boston, Massachusetts, USA
[11]Harvard Medical School, Boston, Massachusetts, USA
[12]Oglala Lakota Nation, Oceti Sakowin Land, Palo Alto, California, USA
[13]School of Engineering, Stanford University, Palo Alto, California, USA

Twitter Marina Schor @marinaschor

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ORCID iD
Marina Schor http://orcid.org/0000-0001-8327-9235

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