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Editorial

Privilege and inclusivity in shaping Global Health agendas

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Northern voices dominate Global Health discussions. Of recent Lancet Commissions, excluding representatives from international organizations, 70% of commissioners on the Women and Health commission came from the global North, and likewise, 71% of the Health and Climate Change commission, 72% of the Global Surgery commission and 73% of the Global Health commission (Lancet 2016). Only two out of the 16-member Board of Directors of the Consortium of Universities of Global Health come from the global South (CUGH 2016). No current or past president and only one current member of the World Health Summit's scientific committee is from the global South (WHS 2016). Only one of the 17 advisory board members of the journal Global Health Governance is based in a low/middle income country (LMIC) institution (GHG 2016).

Only 15% of the world's population lives in high-income countries. Yet Global Health conferences continue to be dominated by invited Northern speakers and important committees on Global Health composed mainly of Northerners. The words of a few from the global North wield a disproportionate power that carries well beyond their own boundaries. How can it be acceptable that these groups continue to dominate in deciding what problems we think about in Global Health and how we approach them?

The lack of inclusivity in Global Health carries major risks for the field. The most excellent research study or Global Health program risks failure unless it is informed by and contextualized by the people close to where change is sought. The Ebola crisis starkly illustrated the follies of a top-down system of global response to local health problems, and the crying need to develop local institutions and systems, access the experiential and tacit knowledge of local and country actors and listen more closely to voices from the ground (Wilkinson and Leach 2014). It is neither conscionable nor accurate to make the excuse that there is not enough technical know-how or expertise in LMICs to accommodate more such voices. Widening the breadth of participation in key discussions is critical to accessing different forms of knowledge, capacity and intelligence.

How then can discussions in Global Health begin to embrace global diversity? Social media initiatives such as the recent list of 300 influential women in Global Health and the campaign to reject men-only panels (#allmalepanels) have had some success (Graduate Institute 2015; Twitter 2016). Perhaps a new hashtag to protest how northern elites shape development debates would have an impact, but it will only be a start.

The question of inclusivity calls for multiple approaches. Intersectionality—the study of how privilege and disadvantage are linked to overlapping social identities—holds promise in deepening our understanding of inclusivity. Understanding how one axis of disadvantage (e.g. gender) may operate contiguously with others (e.g. working in a low income country, non-Anglophone, young), helps us better conceptualize complex social hierarchies that more accurately mirror real-life experience (Larson *et al.* 2016).

Action to promote inclusivity and diversity is not free of pitfalls. One relates to the politics of representation, where particular individuals or groups become associated with specific constituencies and are repeatedly invited to represent the interests of that constituency. This is linked to homogenization—when the views of so-called representatives become conflated with the needs of an entire group or country, however heterogeneous in reality. We need to push towards real inclusion so that diverse voices are not just brought to the table but are empowered to shape the debate and set the agenda.

What practical steps might be taken to improve inclusivity in Global Health? Codes of conduct for Boards and Commissions concerned with Global Health could be framed to encourage inclusion of individuals from the global South (as well as other underrepresented groups), and provide standards to judge inclusivity. Global meetings could be held more frequently in LMICs and support more participation from poorly represented regions and groups through financial scholarships. Conference programmes can ensure the inclusion of LMIC-based and non-elite speakers. Innovative session formats that maximize participation help make conferences less inhibiting and hierarchical, and can promote different styles of intervention and dialogue. The top Global Health journals should be more open than they currently are to qualitative research—the recognized scientific approach for listening to diverse voices and accessing diverse experiences (Daniels *et al.* 2016). Initiatives such as fee

waivers and reductions for open access publication by LMIC authors have been implemented by several Global Health journals, but need to be expanded.

Underpinning these practical measures, the Global Health community needs to reflect on whom it is seeking to serve, and better articulate the shared values and principles that it espouses. Such principles might encourage us to promote the involvement of people who have historically been marginalized, reflect on how benefits of our work are distributed among participants and encourage all involved in Global Health to work with a degree of introspection and humility (CCGHR 2015).

The Global Health community needs to be the change it wants to see in the world, and take a pledge for greater inclusivity. Inclusivity does not end at representation—it is a way of thinking and working that must be written into the fabric of Global Health so that the field becomes a learning system and community, and ultimately more relevant, where it is needed most.

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