Original Research

Prejudice in Health Professions Education - The Botswana Story

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Many African countries are involved in complex plans to improve health professions education as part of health sector strengthening. Global health ventures have joined in, to address the scarce human health resources through either research and/or service. These enterprises of global health have come at a huge cost to careers of trained citizens and the countries at large. Botswana is no exception. In 2010, the University of Botswana was awarded the US NIH medical education grant and partnered with excellent and well-established universities to capacitate the newly established School of Medicine. Within the Botswana health-care-sector, these same universities had established affiliate institutions to contribute to the Botswana health systems. Rather than empowering citizens, these partnerships have instead become conduits for career development of faculty and researchers from the west. Tipping the scale further, the University of Botswana leadership places the western institutions' interests far above the interests and development of the local faculty and thereby the country at large, stalling the country's nation building vision thereby, sustainable development goals.

INTRODUCTION

For many years, most countries in Sub-Saharan Africa have been counted among those overwhelmed with high disease burdens and high patient-doctor ratios.[1] This has come about due to an array of impeding factors ranging from infrastructure to human resources. It stands to reason that it will take some combination of these factors to reshape the continent so that healthy workers can be released to grow Africa economically. To this end, African countries are involved in complex plans to improve health professions education as part of health sector strengthening.[2] These sub-Saharan African governments are investing heavily in human resources for health in response to the urgent need.[1] During the first decade of the 21st century, sub-Saharan Africa witnessed the initiation and establishment of a large number of medical schools to address the health challenges in the region.

Global health ventures at more than surmountable scales, from the west, have joined in to address the scarce human health resources and health needs through either research and/or service.[3] Botswana is no exception. Seventy-seven percent of Botswana's healthcare workforce, comprising mainly of nurses, were trained locally.[4] To further improve the health system, medical doctors and other allied health professions have been trained internationally. Prior to the opening of the medical school in the University of Botswana (UB), after 43 years post-independence, all medical doctors were trained internationally. The impact of the UB medical school venture may never be quantified, especially its significance during the era of the COVID-19 global pandemic. The University of Botswana School of Medicine admitted its first cohort in 2009.[5] To date, the medical school has graduated about 425 medical officers including specialists. The focus of this article is to highlight the discrimination and prejudice that African health professionals/scientists experience in their home institutions as a result of global health partnerships and endeavours.

GLOBAL HEALTH – PART OF THE SOLUTION?

To date, Africa has evidenced a growth in global health, an academic field/speciality, in which high-income countries (HICs) faculty (academics and researchers) and students visit low- and middle-income countries (LMICs). These visitors come in to learn about new cultures, settings, and diseases and, possibly develop an expertise to address existing and emerging challenges in these countries.[6] Indeed, African countries intensely benefit from such a global endeavour. However, these global health ventures are not equitable to the capacitation of LMIC researchers and academics. Furthermore, transactionally, LMIC professionals' opportunity to visit HICs is significantly limited as evidenced by the definition of global health. Historically, definitions of global health were not usually inclusive. They reflected the current trend in practice: of shipping knowledge, expertise, and resources from the west to the south. The newer definition by Koplan et al.[7] defines global health as: "an area for study, research, and practice that places a priority on improving health and achieving health equity for all people world-wide". It encompasses more complex transactions between societies: emphasising the mutuality of real partnerships, a pooling of experience and knowledge, and a two-way flow between developed and developing countries.[7] Thus, global health uses the resources, knowledge, and experience of diverse societies to address health challenges throughout the world.[7]

Godoy-Ruiz et al.[8] emphasized that international collaboration in academic medicine is one of the most significant ways by which research and innovation are con-

ceptualized, developed, and disseminated on a global scale. Undeniably, major efforts to increase international health research collaborations between HICs and LMICs through exponential growth in funding were made in the previous two decades.[9-11] These partnerships and collaborations are essential and important for Africa to overcome the health challenges and to strengthen its health care systems as well as to improve research in health. However, the disproportionate power imbalance in these collaborative relationships with some of the HIC collaborators and institutions impedes and undermines the enormous mission to bring expertise, funding, and resources to Africa in a true collaborative sense. As an example, these global health institutions mainly come from diverse populations that have multiple races. However, on the ground, visiting professionals from the west constitute of one race predominantly. The singularity of race in these global health ventures to Africa from the west is intriguing. This highlights the prejudices in global health even within the visiting global health professions and institutions to the LMICs. We therefore submit: the adamant issue of race in the imported health care services and research permeates throughout the global health ventures.

As Wondimagegn et al.[12] state, African scientists and health care professionals have surmountable obstacles to overcome to transcend the confines of the continent and hence become globally competitive. In their article, they emphasised obstacles such as visa approvals, and other resources that impede professional development. Consequentially, these rudimentary impediments hamper African scientists and health care professionals from getting international recognition and acknowledgement of their core expertise. Macfarlane et al.[13] asserts that North America uses global health to benefit their interests. This in part has led to most of the inequality in the partnerships that have left most African countries, like Botswana in a perpetual state of minimal health professional research, growth, and development. Crane[14] highlights that, "academic global health depends on steep inequalities for its very existence". Furthermore, Boum et al.[15] continue to assert that, "Global health partnerships between researchers in the West and in Africa are often imbalanced, supporting the careers and priorities of the former, than the latter." This is the position that we find ourselves in as academics at the University of Botswana.

PREJUDICE IN HEALTH RESEARCH

Within the continent, there are a handful of countries that have established functional research funding bodies such as South Africa.[16] Research funding from Africa accounts for only 1.3% of global expenditures even though Africa makes up about 15.5% of the global population.[17] Global health has increased the number of HIC investigators conducting research in LMICs.[18] In Botswana, after 56 years of independence and 40 years of establishing the first university in the country, there is still no national structured mechanism of research funding. Rather, the University of Botswana has what may be viewed as preliminary funding for early researchers, pilot studies, to consequently assist in grant application for larger and more sustainable funds for health research internationally. Henceforth, research in Botswana is dependent on funding opportunities that are available from international sources. As competitive as it is to be awarded international grants, the competitive environment is further exacerbated by the fact that several universities, mainly from the United of States of America, have established independent affiliate research institutions in the country. These affiliate institutions partner with the country's highest health institution, the Ministry of Health (MOH) for service or/and research. The benefits of partnering with the MOH comes with the advantages of these institutions being able to leverage some of their research resource needs through the Ministry's service mandate. Comparatively, local researchers struggle with the fundamentals of day to day running of the university (teaching and learning). On the other hand, the affiliate institutions have the clout of leveraging their time, skills, and resources in grant writing via well-established mentorship programs and network opportunities at their home universities and institutions. A compounding factor to this competition in research grant applications is that the affiliate institutions qualify as applicants in most of these grants intended for sub–Saharan Africa. Consequently, in Botswana, competitive international applications for health research grants are won by the affiliate institutions thereby continually affording them leadership in grantsmanship both locally and abroad. As a result, the local researchers and faculty become despondent due to lack of leadership opportunities in research. In contrast, some of the local researchers who are in leadership positions are offered to be principal investigators or collaborators in some of the grants that they have not participated in their grantsmanship i.e., the writing nor generation of research ideas. Having local investigators/co-investigators gives the appearance of an authentic consultative grant collaboration. In reality, more often than not, the local researchers were either minimally involved in the writing of the grant or they are just token grant holders.

In 2010, the University of Botswana Faculty of Medicine (formerly, School of Medicine) was awarded the Medical Education Partnership Initiative (MEPI) grant by the United States of America National Institute of Health. The Medical School partnered with excellent and well-established universities from the west to build and capacitate the local academics and staff. However, almost ten years after the MEPI grant ended, the only molecular laboratory (MEPI-lab) that the university has is still run and managed by one of the collaborators from the west with the full endorsement from the university executive management and leadership. It is a David and Uriah's situation (Holy Bible, 2 Samuel 11). This scripture speaks of an extremely wealthy and powerful king taking and slaughtering the only lamb that the poor man's children had as a pet. Within the Faculty of Medicine, there are experienced local Molecular Biomedical scientists who have expertise in lab management. The Biomedical Sciences have 13 PhDs who have trained in universities in Europe, South Africa and USA with specialties ranging from Biochemistry to Immunology. These individuals have peer reviewed publications and have been

Table 1. The Bibliographic Data for Botswana Global Health Partnerships – Authorship by Botswana Academics and Researchers: A 10 Year (2013 - 2023) Publication Analysis

	University 1		University 2		University 3		Partnership 1		Partnership 2	
Authorship	**1st**	**Last**	**1st**	**Last**	**1st**	**Last**	**1st**	**Last**	**1st**	**Last**
Botswana Authors	5	4	1	2	16	11	23	12	82	48
Total Publications	13	13	12	12	162	162	210	210	401	401
Percentages of Botswana Authors	**38.5**	**30.8**	**8.3**	**16.7**	**9.9**	**6.8**	**11**	**5.7**	**20.4**	**11.9**

Publication outputs from Botswana in health research are mainly authored by the western collaborators. They are either lead authors or senior authors. For the recent ten-year period, percentages of Botswana Authors range from 6% to 39%.

Publication Search Parameters

The bibliographic data for Botswana Global Health Partnerships publications including universities and partnerships was obtained from *Web of Science*. The affiliation searches were conducted where partnerships had independently identifiable grouping of research publications on *Web of Science*. Where partnerships were tied to affiliations that are multi-context, reporting on overall publications than just Botswana, we conducted affiliation searches and filtered by country (Botswana). The bibliographic data was exported to Excel for analysis. The searches were conducted on only one database (*Web of Science*).

trained as well-rounded researchers in reputable universities and laboratories. In spite of these credentials, the University of Botswana leadership and the partnering institution's posture is to deny local researchers the only lab that could be used for meaningful cutting-edge research. This places the locals in the rut of ever being left behind in research and publications and always looking up to the west with a saviour mentality outlook. This scenario affords no opportunity to the local researchers to hone and improve their skills. The University of Botswana signed no memorandum of understanding for the MEPI lab. With no agreement signed between the parties, a perpetual assumption of running the MEPI-lab with no time-limit entails. This is a discord to the core value of what the original MEPI grant entailed: capacitation. This is exacerbated by the fact that the western collaborator continually expects the University to bear the costs of equipment maintenance and utilities.

Publication outputs from Africa in health research are mainly authored by the west.[19] They are either lead authors or senior authors. Sub-Saharan Africa (SSA) contributes less than 1% of biomedical science publications.[20] Similarly, this is a trend observed in Botswana regarding publications and grants. For the recent ten-year period, percentages of Botswana Authors range from 6% to 39% (Table 1). The major reason is that the west has more grant funding opportunities, predetermined career pathways including very well planned and maintained mentoring research programs. The affiliate institutions come from very high-ranking and well-established universities that have been doing research for hundreds of years. It is not surprising that the west are leading in publications because of the supporting factors mentioned above. The peculiarity of the majority of grants for Sub-Saharan Africa is that they have a capacity building objective. Institutions and universities from the west and their affiliate institutions should rather take a back seat to mentor and capacitate LMICs in research.

Data is the currency of the 21st century. Advances in scientific research produces remarkable and significant amounts of data that impacts not only in health and scientific research but leads to exceedingly gross amounts of capital income over time. In global health research, HICs derive enormous amounts of data from the developing world, especially Africa, making them increasingly data intensive.[21] We reiterate that partnerships and collaborations are important for the development and progress of health care and service. However, there needs to be equity in ownership of the data. Material transfer agreements, intellectual property and ownership of data extracted from the developing world should be crucially evaluated. The University of Botswana Office of Research and Development has these factors in place regarding documentation. Even with these agreements in place, some of them are not fulfilled.

Within the health care sector, the affiliate institutions are primarily designed to contribute to global health through partnership with the government. Rather than empowering citizens, these partnerships have instead become conduits for career development for the partnering institutions and their universities. This has extremely undermined the local faculty, rendering them to be viewed as incompetent. In the health service, the already constrained health care system is over-stretched to extend and supervise an influx of novice interns into the country in the name of global health.[22] The western institutions have unprecedented access to Botswana's governmental bodies in ways that are not available to local researchers. This gives the distorted notion that there are no local experts on given topics. The result is that the local researchers do not have a voice in decision making and policy matters that affect the country's population.

THE COMPOUNDING EFFECTS OF RACISM

Leadership at the University of Botswana places western faculty and institutions interests far above the primary interests, development and capacitation of the local faculty. As an example, there are senior executive positions that the management of the university has a silent stand on and, reserve for individuals coming from the west. The prejudice and discrimination of local faculty to advance is therefore an accepted practice at the University of Botswana. Furthermore, there is a discordant reward system within the Faculty of Medicine. Ironically, the locals have studied, competed, and excelled in institutions in the west with the

same caliber of collaborators. They have proven themselves to be competent according to international standards. This discrimination comes at a huge cost to the careers of locals and the country's economy. Bailey et al.[23] describes institutional racism as, "organizational policies, practices, and procedures that intentionally or unintentionally discriminate on the basis of racialized group membership". As much as Africa has outgrown her colonial history, when these partnerships are set up, either intentionally or unintentionally, the west is still indignant in remaining as colonial masters. As Eichbaum et al.[24] states, the crossroads between colonialism, and academic medicine and global health research have created a "neo-colonial narrative that perpetuates inequalities in global health partnerships". This perpetuates a cycle of dependence on scholars from the west. To break the cycle, there are multiple and complex factors that LMIC research institutions need to establish, such as, structured mentored programs, investing in an enabling environment for teaching and learning and awarding positions on merit. Furthermore, fundamentally, African governments need to invest in well-structured research funding bodies.

LEADERSHIP IN PROMOTING HEALTH STRENGTHENING

In an ideal environment, an effective leader is someone who is visionary, credible, influential, and flexible.[25,26] Richards[27] and Mennin et al.[28] emphasise that a leader should also be able to facilitate open communication and honour diverse views, be enthusiastic and, create a supportive environment for growth. Some of the gaps in the leadership qualities may be the principal causes of disparities in global partnerships. In the global research collaboration development, African leaders should insist on creating more equitable partnerships. This requires a shift from the current paradigm that dominates most international partnerships which cause injury to African researchers and scholars. Nordling[16] states that "commitment to science" is lacking in African governments and, this contributes to African scientists being dismissed by western partners. Throughout the years, the University of Botswana has signed memoranda of understanding with many universities for partnerships and collaboration within the continent and abroad. These contracts are not always advantageous to the local faculty. Within the multi-layered hierarchies inherent in the processes of formulation of partnerships, equity needs to be factored in at every stage. African institutions need to develop and support structured mentoring research programs for the local researchers and faculty that will propel their faculty's career trajectory. We believe the perpetuation of an imbalanced partnership is a result of biased leadership from our institutions. These leaders still foster the belief that "one who brings funding" has the power and the impetus to dominate in the partnership. In this, they fail to acknowledge the immense and priceless resources the LMICs bring to the table. Clearly, the leadership is compromised. To reiterate, in the 21st century, data is the currency of the day for both science and innovation. The very research that international investigators are interested in requires data extraction from samples obtained in LMICs. This is an immense and valuable resource that should not be simply matched to monetary funding. The leadership are the enablers of the discriminatory practices against the local academics and researchers. To quote an old saying and analogy: "it is easier to change the location of a cemetery than to change a curriculum" (Author unknown). As Bland et al.[29] affirm, substantially, the success of any curricular change happens because of the direction and influence a leader is passionate about. The pinnacle element to change here is leadership.

INDIVIDUAL INEQUALITIES: THE "SO WHAT"

There is a general lack of acknowledgement from the leadership in viewing local academics as knowledgeable and experts in their field. Indeed, Gautier et al.[30] supports our view that there is a broad lack of consideration for local experience and expertise. In the writing of research proposals and manuscript development, the trend is for local researchers to passively be involved in the processes and only sign for acknowledgment of their meagre participation. At times, the participation by LMICs is reduced to technical levels while the "meat of the science" is performed in the west. Further to this, local leadership is not understanding of or, they turn a blind eye to the predicament of local academics because they are part of the international research investigator's teams. They protect their research interests and career progressions. Generally, local researchers, LMICs, are afraid to write on this subject of partnership discordancy for fear of lack of future funding, collaboration, and publishing because of the "mafia style in science" that has the potential to impede one's career progression. Zarowsky[31] emphasizes that a significant building block for a successful partnership entail "tolerance for disagreement and, taking time to build and maintain trust".

DISCUSSION AND RECOMMENDATIONS

We submit that the leadership must look at African academics and scholars with a different filter that is objective, supportive and career building. This may be one of the turning points in reversing the brain drain of African scientists and scholars. Furthermore, institutional discrimination obliterates the competitiveness of local scientists and scholars because of preferential treatment of the west and their in-country affiliated organisations. The prolonged/retracted discrimination leads to a loss of leadership opportunities both locally and internationally for LMICs academics and researchers. The solution to effect change is altering the mindset of leaders locally. This requires that leadership see local expertise as being beneficial to the country's growth for long-term investment in developing the nation.

There are several inputs that global partnerships through HICs contributed to the development and capacitation of research at the University of Botswana. As an example, in 2010, the University of Botswana School of Medicine, through collaboration with universities in the west were awarded the MEPI grant. To mention a few, the Family Medicine MMed programme as well as the Public Health

Medicine MMed programme were initiated and developed through the planning, support, and assistance from the MEPI grant. Through the MEPI grant, the school bought clinical skills simulation equipment, video conferencing facilities established in four teaching sites. In addition, WIFI connectivity and library for students and faculty to access teaching and learning materials were established in these sites. The grant also helped accelerate the infrastructure in these teaching sites. The grant also supported professional development for some faculty and, initiated networking and mentorship endeavors. Despite these very important health research capacity building ventures, the advantages are still skewed towards the HICs. We have formulated the following recommendations to join in this dialogue of creating equitable partnerships and collaborations in global health:

1. **Strength in diversity of ideas as well as cultural sensitivity**
   Diversity is always a welcome venture as it enriches research and researchers to be agile in seeking solutions that work per each specific community. Henceforth, we postulate that global health is essential for the improvement of health of all peoples and research advancement. However, all parties need to be sensitive towards each other's needs and cultural context. Collaterally, ideas that are brought to the table should all be equitably shared and discussed. There needs to be mutual respect between parties, more especially, the recognition that, the global south, even though they are LMICs, they are experts in their own right, within their settings.
2. **Establishment of a National Research Funding body**
   This recommendation, for an establishment of a national research funding bodies, has been echoed multiple times to governments in LMICs.[16,17] Local academics at the University of Botswana compete with researchers from institutions who are from well-established western universities for funding opportunities from international grants. This snowball effect is that grantsmanship, research, research training and authorship from LMICs continue to be less developed leaving research dominance in the west. Crane[14] states that, survival of global health is contingent on the steep inequalities between LMICs and HICs, which remains advantageous for HICs. It incumbent upon the LMICS to establish national research funding bodies to help bring equity.
3. **Research collaborations and partnerships should be anchored and grounded between university-to-university agreements**
   Partnerships between LMIC ministries of health and academic institutions from the west warrant critical evaluation. The almost non-existent funding for health research in LMICs greatly influences the power balances in research partnerships endeavours. Our recommendation is that the LMIC governments and university leaderships need to direct interested research partners to equitably and primarily collaborate and with local universities and research institutions. Although there are exceptions, we emphasise that collaborations and partnerships, especially for research, should be anchored and grounded between university-to-university agreements. Within these partnerships and collaborations, there needs to be intentional organic growth of local expertise. Ultimately, the LMIC community should benefit.
4. **Institutional Prejudice**
   At institutional level, researchers and academics at the University of Botswana continually endure discrimination and prejudicial practices that are rampant and endorsed by the leadership. These practices impede LMIC scholars' promotion to leadership positions. We recommend that the university leadership needs to develop, recognise and acknowledge the expertise of local researchers. Furthermore, the contributions that these academics bring to the institution must be equitably rewarded in the same manner as when the position was occupied by the west. In their decision making, leadership should work to diminish the compounding effects of racism by prioritising promotions of local scholars and researchers, based on merit.
5. **Robust mentorship programs**
   Leaders who care about the professional growth of their employees and their organization at large have a greater impact in nation building. The LMIC academic and/or research institutions should have leverage on global health initiatives to develop robust and structured mentorship programs that work and benefit their researchers. To reiterate, as HIC networks reach out, leaders in the LMICs should and must insist on equitable partnerships that capacitate local scholars and researchers and are sustainable to the development of the nation.
6. **Leadership in LMICs Universities**
   Leadership is the problem. Leadership that is supportive and that prioritizes capacitation of local researchers and scholars is essential for growth and sustainability of LMIC institutions. As a consequence, the researchers and scholars will be passionate, committed and dedicated to the mandates of their institutions. They become well-rounded holistic individuals who are excited about partnerships and collaborations with institutions from HICs and will be on an organic growth trajectory. Racism and prejudice births racism and prejudice: People are suspicious about each other's intentions. Nation building can only happen when there is a deliberate intention by leadership to empower their own local researchers and scholars and support them to become expertise and leaders in their fields.

SUMMARY

We are drained and fatigued by the "emotional tax we pay" for being African. To echo the words of Wondimagegn et al.[12] emotional tax is the fear of being stereotyped, being treated unfairly, being made to feel like the "other"—setting

us apart from other colleagues on the basis of some aspect of identity such as race or ethnicity. All venues of academia need to be equitable. The politics of power and elitism must be resolved in order for African scholars to make their mark in the world. African leadership needs to awaken and insist on equitable global partnerships that promote healthy collaborations and professional development opportunities for all.

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