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UE: Utibe Essien, MD, MPH

CO: Chioma Onuoha

DP: Dereck Paul, MS

MM: Michelle Morse, MD, MPH

PF: Paul Farmer, MD, PhD

UE: 00:11	[music] This is Utibe Essien and welcome back to another episode of the Anti-racism in Medicine Series of the Clinical Problem Solvers podcast. Where, as always, our goal is to equip our listeners at all levels of training with the consciousness and tools to practice anti-racism in their health professions careers. Today's episode is titled Anti-racism: Global Health Equity and the COVID-19 Response. I'm joined today by my brother Dereck and by a new voice on the pod who's been working hard behind the scenes and we're super excited to announce as our new managing editor for the podcast, Chioma Onuoha. Chioma, welcome to the podcast.
CO: 00:53	Thank you so much, Utibe. I am so excited to be here. My name is Chioma Onuoha. I am a recent graduate from Harvard College and currently a research assistant at the Johns Hopkins Center for Health Equity, where I will be working until I started med school in the fall. Needless to say, I am so excited to be in community with my team members and our fantastic guests. And I will hand it over to Dereck to announce exactly who those guests are.
DP: 01:17	Thanks, Chioma. And I just want to say again how excited we are to have you in that new role. And for folks who don't know but have listened to the episodes we've put out before, Chioma has just carried so much of what we do. And she's been the managing editor, we're just announcing it officially now. I have the honor of introducing our guest today. Dr. Michelle Morse is Assistant Professor of Medicine at Brigham and Women's Hospital and Harvard Medical School. Co-founder of EqualHealth, an organization dedicated to the support of our Haitian colleagues in the health professions. She's the co-founder of Medicine Consortium, a global coalition championing the discipline of social medicine. She's most recently been a Robert Wood Johnson Foundation Health Policy Fellow at the National Academy of Medicine. And I think it was just last week, or maybe the week before, became the first chief medical officer of the New York City Department of Health and head of the Center for Health Equity and Community Wellness. So, Dr. Morse, welcome to the podcast.
MM: 02:25	Thank you so much for the generous welcome. I'm honored, honored, honored to be in this conversation with you all today.
DP: 02:33	Dr. Paul Farmer is a distinguished Professor of Medicine and Chief of Division of Global Health Equity at the Brigham. Chair of the Department of Global Health and Social Medicine at Harvard Medical School. Editor-in-Chief of the

journal Health and Human Rights. He's the co-founder of the storied and celebrated nonprofit Partners in Health and author of many books, the latest of which is Fevers, Feuds, and Diamonds: Ebola and the Ravages of History. Dr. Farmer, thanks for being with us today.

PF: 03:04 It is a treat. It's a treat. Thank you for having me.

UE: 03:10 Many of our listeners may not have had an opportunity to think very much about the response to COVID-19 outside of our local communities, much less outside of the US. In some ways, this is part of a pretty typical US-centric way of thinking, which is common in medicine and also at society at large. Dr. Farmer, I'll start with you. And again, Michelle - Dr. Morse, sorry - please jump in as you feel comfortable.

MM: 03:36 Now, in New York City, they've started calling me Dr. M. That's the new name.

DP: 03:40 That's good. I like it.

MM: 03:42 Not bad, right? [laughter]

UE: 03:43 I've got to give Michelle her flowers. So from now I will call you Michelle if that's okay. But for the culture, of course, you are, Dr. Morse. But anyway, Dr. Farmer, I'll start with you. So what's your interpretation of where--

PF: 03:55 Please, please, please, call me grandpa. [laughter]

UE: 04:01 I'll say pops. Pops, I'll start with you. So what is your interpretation of where this US-centric way of thinking comes from? And how did you become a champion of global health over the years?

PF: 04:16 I don't know what it's like, for example, to grow up being a British kid or a French kid or any other colonial rule kid. I don't know if this US-centric matter is defined by nation-state where one's born citizenship. I don't know. If it were only that there wouldn't be a whole literature on American exceptionalism, right? But I think what we do know about the COVID response is that we would be ill-advised to pursue a lot of the measures taken in the United States. So I'm talking about, I mean, politicization of mask-wearing, of contact tracing, the nature of our rollout. It's hard to point to an arena of COVID where we haven't done fairly poorly.

PF: 05:11 However, there's a couple where we've done very well. One is the basic science establishment. The American basic science establishment has been deeply involved in the work that made the vaccines possible. So even the President of France, since we're talking about decolonizing global health, pointed out that, "Yeah, well, the Americans haven't done a good job on anything but the vaccines." And the other point I think that is pertinent to your question is going to be around financing vaccine acquisition. So the Biden Administration just made a major contribution to this. So that doesn't solve the problems or get us toward the goal that we all share, which is not only universal vaccination coverage, but a particular focus on those who are most at risk. And they're at risk of two things. One, getting sick and two, dying. Getting infected, and two, dying. Because those are two different processes.

PF: 06:16 So I think right now, American exceptionalism looks two ways. One, our poor response with a real reluctance to engage in aggressive containment as a nation, which is not something we see everywhere. Sometimes they're too aggressive at containment. And the other is the possibility for international

solidarity remains strong, I think. And that'll be in part through stuff like vaccines. Sometimes through staff. People who could be helpful. Although that's probably less necessary than we think. And sometimes it'll be through solidarity that would allow us to give significant support to rollouts elsewhere. Myself, I'm thinking a lot about Rwanda these days. Sorry if that was too long.

UE: 07:06

No. I love that. I love that. Stuff, staff, and solidarity is what I heard. Michelle, I'd love to pose the same question to you. How do you think about this US-centric framework here in American medicine and how did you become a champion of global health?

MM: 07:22

Yeah, no, I think it's such an important question. And sometimes we don't even ask it, right? And I think that's in some ways that's kind of how imperialism and settler colonialism work, right? Just like other systems of oppression, it's kind of like, you don't even think to ask the question. Because it's such an embedded part of how you were brought up or what you were taught to think, or, again, kind of the cultural hegemony side of things. So in some ways, kind of not asking that question is a defining characteristic of imperialism and settler colonialism. And I think we don't talk enough about how those systems become internalized and shape the boundaries of our thinking. We shape the boundaries of our dreams and our creativity often without us really realizing it. So I think it's a huge concern, of course, because we don't have enough of the critical consciousness kinds of training and frameworks as we need in medicine and across the US, in general.

MM: 08:26

So I think many Americans are really, truly not aware, right? Truly ignorant, unfortunately. And that can change, right? That's the beautiful part about it, I guess. And that's what social movements are so beautiful for, right? It's critical consciousness at scale. And so I really see that as kind of one of the key frameworks for why this American-centric spirit exists. My mom is a public school teacher and taught in Philly public schools for a very long time. And especially as her daughter, I have to say part of it is also failures of our public education system and its investments in the public education system, right? It's that we don't give our system the tools and the resources it needs to thrive and to succeed and to raise a new generation of conscious Americans who understand that history and understand what settler colonialism means in the United States of America and understand what imperial domination of the global economy by the American Military and other American systems of power. What does that mean, right? I would love for high school students in America to universally be able to talk about that. We would have a lot more hope as a country if that were the case. So I have to lift that part up.

MM: 09:54

But personally, I got involved in all of this through the AIDS movement. And I'm now officially getting old because that probably seems like ancient history to a lot of folks. But the AIDS movement when I was coming up, was where folks who were interested in health justice all flocked to or all got drawn into. And for me, that was a combination of kind of being in West Philadelphia, which is where I'm from and where I went to medical school, and going to ACT UP Philadelphia meetings with a bunch of amazing activists when I was a medical student and learning about why Black and Brown folks were the folks who were dying all around the world and in the US disproportionately from HIV.

MM: 10:46

And then I had the privilege and honor of getting to spend a year in Botswana from 2006 to 2007. And at that time, Botswana was the first country on the

continent to start a completely free and fully accessible, publicly funded HIV/AIDS treatment program. And the life expectancy at the time in Botswana was 36 years. And so, again, making those connections between life expectancy for Black men in West Philly was in the late '50s, right? And then seeing those same patterns of, again, extractive policies, oppressive policies, structural violence, systemic racism, settler colonialism, racial capitalism, all those things, seeing them in those two contexts, my home neighborhood and then in Botswana, I think, is what sold me on this being kind of my life's work, engaging in this work and trying my best to be humble about it. Because clearly, we haven't figured it out. But that's kind of what brought me to it.

CO: 11:52

Great. Thank you so much for contextualizing, kind of, your own 'why'. It's really interesting to think, especially right now, so many students are probably seeing COVID-19 as the reason why they're so interested in health equity, and kind of the cycle continues. But kind of along the lines of a lack of consciousness that might happen, maybe a lack of education that is being taught to not only our grade school students, but also our medical students and our medical professionals. I would love to hear from both of you, And I'll start with you, Michelle, why do you think that American health professionals, especially those who may feel like they don't necessarily have a stake in global health equity, why should all American health professionals be concerned about the global response to COVID-19? And this could be from a moral perspective, from an anti-racism perspective because, of course, that's what we focus on here. But why do you think this should be something that all American health professionals are concerned about?

MM: 12:50

Yeah. Absolutely. It is another phenomenal question, and I'm thankful to get to comment on it. I mean, I think it's ultimately about collective survival and it's also about really an acknowledgment of our interdependence. I think those are two of many reasons why this should matter, right? I mean, I think we are in many ways constantly fighting the medical-industrial complex as health workers, especially in the US, trying to reclaim the healing aspects of our profession, the creative aspects of our profession, the parts that can't really be commodified easily. And sometimes I feel like we're losing, unfortunately. But if we really amp-up that fight and pour some more fuel on that fight, then this kind of approach to seeing health and well-being as a global endeavor and not-- sorry. Are you hearing the sirens really loudly? Yeah. Okay. I'm definitely [crosstalk]--

PF: 13:57

They're probably [crosstalk]. [laughter]

MM: 14:02

It's the feds.

PF: 14:03

You're ambulances now. Good luck.

MM: 14:08

Oh, it's something bad because that fire truck is going the wrong way down a one-way street, so something is happening. Something is always happening in Bed–Stuy is what I'm realizing. So any ways. If we're serious about really reclaiming that history and kind of the heart and soul of medicine and the healing aspects of medicine, then seeing the fight against COVID and this pandemic has to be seen as a internationalist and interdependent fight. And I think we just have a chance right now. I mean, as American health professionals, we have a tremendous amount of power. Often unfairly, right? Physicians often have an unfair amount of power in health systems in general, but that's a conversation for another day.

MM: 15:00 But as Americans and as health workers, we do have a lot of power when it comes to being able to actually interrupt colonial and imperial patterns that our very own government is perpetrating. So I was thinking about this analogy of how White people tend to listen to White people more when it comes to racism. And the American Government tends to listen to Americans more than folks in the Global South when it comes to critiques. We have a really important role in holding our own government accountable in that way. And I think that that's another really critical role that American health workers can play in, again, the global fight for social equity and global health equity.

CO: 15:51 Great. And Paul or Pops, if you have anything to add, why you feel--

PF: 15:56 That really [crosstalk]--

CO: 15:56 [crosstalk]-- oh, sorry. [laughter]

PF: 15:59 Pops has a point to make, but it's really only to second Michelle's points. But I would add that I think it's a good idea to for us to be-- in other words, if you look back at a lot of previous epidemics and pandemics, and even drug-resistant tuberculosis or HIV, there's always this movement when something is declared new to underline either the peril of it or how we're all in this together. And first of all, we're never all in this together, as we know. I'm talking about strains of commentary. So I'm 61 and I started medical school in 1984. And so you can just do the math. AIDS and HIV were really central to the medical education of nurses and doctors during those years, between '83 or '84. If you went through a med school residency fellowship in that decade, that was really the middle of it all.

PF: 17:14 And I, too, was very inspired by AIDS activism. And particularly around drug development, delivery of care. In other words, the material things. Which is one reason I keep going back to staff, stuff, space, and systems. Because, yeah, I know there are cultural phenomenona. I'm an anthropologist, too. I know there are cosmological and religious phenomena. We study that stuff. But it's really important to keep going back to the material. Like, "How are we going to roll this out?" And Michelle just mentioned the main reasons to be aggressive about this. The two paradigms I was talking about, the paradigm of fear and the paradigm of solidarity, I think we should not give up on the paradigm of solidarity. In other words, it is necessary that we do this because, unless everybody's safe, nobody's safe.

PF: 18:14 You look at the tail end of smallpox and where the epidemics kept occurring in spite of massive global vaccination efforts. I mean, when I say massive, we could be doing-- between 1796 and 1977 you have a lot of time to roll out what has essentially been a safe vaccine for a pathogen without a nonhuman reservoir, right? And the vaccine was safe even back when it was lousy, right? And then it got safer and safer and safer. And still, you didn't have herd immunity. Still, you had these ongoing clusters of outbreaks with loss of life, and everybody turned to these cultural explanations. And by the way, it won't surprise you to know that they were invariably focused on race. So, for example, West Africa, Sierra Leone in 1966 and '67, I think, reported the largest outbreaks - little, tiny Sierra Leone - of smallpox in those years when it was already declared many times eradicated. It hadn't been, of course. And so to focus on the material response, what are the staff, stuff, space, and systems that we need, was a good idea. It's also a reminder, again, until everybody's safe, nobody's safe. So we don't have to be shy about using that.

PF: 19:43

On the other side, though, a group like this in a podcast like this, we should all be asking the question, "Well, what does solidarity look like? What does anti-racism look like in a COVID response?" Why shouldn't we be asking it just that way? The people who are hosting this call and probably many who are listening to it have already bought into the notion that it's not possible to be passive about racism. You're either for or against it. It's better to be pushed into that position. I was about to say extreme, but there's nothing extreme about it. I think it's a perfectly logical and reasonable answer. So what does an anti-racist COVID response look like? Well, I can tell you some things it doesn't look like. It doesn't look like the worst vaccines for subaltern populations.

PF: 20:40

Michelle, too, Michelle and I have worked a lot not just in Haiti, but in Rwanda, for example, and elsewhere on that continent. And when I say a lot, I mean over years. And we've, both of us, been hearing again and again from our friends in Haiti and across that giant continent and elsewhere here in this place - whereas Michelle mentioned, we have settler colonialism - we've been hearing, "Look, why is it that we always get the shittiest vaccines or why do we get the shittiest medications or diagnostics or care or whatever?" So I think an anti-racist COVID response will not only be thinking about social distancing, masking, how all that's done but what would the vaccine rollout look like? And there's some chances that we'll get a chance-- there's some opportunity that we'll get a chance to see what it might look like.

PF: 21:32

I think with Rwanda, for example, we're likely to see a highly coordinated-- and I imagine both Michelle and I-- well, Michelle may be tied up, but usually, she would be involved. Highly coordinated. Focused on the most vulnerable. Aware of what it is like to be shut out. Meaning, to be so subaltern. The history of that country means that they have to be exceptionally aware of social divisions, right? And so I think we're going to see-- I hope we do get to call it an anti-racist vaccine rollout. Some would say, "Well, everybody looks alike there. They all speak the same language." But even there, there are significant differences. Urban, rural, rich, poor, men, women. So it's going to be an interesting process and one I think that will be tweaked a lot to make it look like an anti-racist-- to make it be an anti-racist vaccine rollout.

PF: 22:32

Now, the real challenge, though, is going to be, in the post-colony where there are still all the vestiges of inequality and race inequality, like the United States, it seems to me that the way we're proceeding now-- I mean, I'm a lucky beneficiary of it, right? And I imagine you are all-- maybe not, Chioma, but I imagine you guys are vaccinated, too. But what about when there's an epidemic or a cluster? What do we do there? Is there an anti-racist way of proceeding? Look, I could go through every single plank of this program - mask-wearing, social distancing, contact tracing, vaccine rollout - and as you could, try and give an example of what an anti-racist COVID response would look like. I think we should do that, and I think we should be doing it right now. And some of you have no doubt been doing that and that's why you're asking the question.

DP: 23:38

Absolutely. It's interesting as a fourth-year medical student to listen to both of you reflect on what the world looked like when you were doing your own training. And I have a lot of conversations with medical students and residents about the way that COVID-19 has fundamentally restructured our education and our rotations. And I think at some point specifically thinking about mentors who had trained at the height of the HIV/AIDS global pandemic,

especially in the early days, I think, "Okay. I'm going to come of age in this time and I know that's going to shape me." I don't know exactly how yet, but I hope that it is. Coming of age at a time when we are doing everything we can to have an anti-racist vaccine rollout, both in the US and everywhere else, you both have done so much work in Haiti and Rwanda, elsewhere. I'm wondering how the COVID-19 pandemic has affected some of that work that you've already done? Some of the progress we've made on some health indicators and areas of focus kind of before COVID-19 pandemic hit? And maybe Michelle, I'll turn to you first.

MM: 25:30

Yeah, no, I appreciate that question a lot. It's been a time for me-- this period of having the privilege of working from home and having to social distance and all of that, it's been a really intense period of introspection and reflection for me. And I have spent a good bit of time journaling and just doing voice messages to myself, just thinking about some of that question, and doing some more of that kind of, again, internal work, that kind of introspective work and have thought a little bit about it. I mean, I think one of the things that's been clear to me just from prior experiences and how that applies to what's happening now with COVID and the global dynamic there, I think part of what I'm seeing that's different is I see us in kind of the health worker community naming racism and colonialism and settler colonialism a lot more, honestly, than my memory of us doing that back when I was a little baby in the AIDS movement I have to say.

MM: 26:45

And I know there were lots of people naming it very explicitly during the AIDS movement. I was 22 and was very, very early in my political consciousness at that point. So I would say for me at least, I think that's a beautiful, critical, essential kind of evolution. And I think that it allows us to have a very different conversation. Because if we're talking about those things, then we're talking about how we execute on interrupting those cycles. Interrupting those forces and fighting them explicitly. And I think that that's phenomenal. And we have to lift up the organizers and folks who've been in the streets since a very long time now, right? At least 2013 when George Zimmerman was acquitted for the murder of Trayvon Martin. I mean, I think that the Movement for Black Lives has done that work, as I was mentioning earlier. The work that only social movements can do of massive scaling of critical consciousness and willingness of people to reexamine themselves, reexamine the work that they're doing, reexamine the society. That is everything. That is everything. I think that's huge.

MM: 28:07

And that, to me, again, for me feels different than my experience in the AIDS movement. In some ways, again, as a baby in the AIDS movement. I think that also, and this is not new, but I also think that students, trainees, medical students like yourselves always have brought the strongest, most direct, most honest analysis and critique. And I hope that continues, right? And that spans all of the spaces that I've been a part of. When there are young folks in those spaces, the best questions get asked and the critical questions get asked and I really appreciate that. So I think just how that relates from my prior experiences in Haiti and Botswana and West Philly and Rwanda to now to me is like there is no space [laughter], there is no space that's going to produce like good new ideas and new ways of doing things that doesn't have young folks as a part of it. And I think that's just essential and critical. And that, I guess, if I'm generous with myself, I perhaps was one of those young folks back in the AIDS movement, and now I am leaning on and learning from folks

like yourselves in the current moment during COVID. So, yeah.

DP: 29:40 Paul, maybe we'll turn it over to you. I'm wondering what about the COVID-19-- when it comes to global equity, what's keeping you up at night right now? And how have some of the initiatives and the work that you've done over the previous decades, how is it being affected?

PF: 30:07 Well, first of all, I find it possible to be kept up at night by fairly specific kinds of problems, which is not the way I see them or experience them in normal, lucid waking hours. In this conversation, for example, what I feel, and I think that you do as well, is that we're talking about many things at once, right? We're talking about COVID, but we're talking about social disparities, about history, about the burden of history, and about-- it's a lot of stuff at once, right? Whereas I can wake up and say, "Oh, shit. What was I thinking about? The vaccine rollout." And so I'm just going to tell you, that's been on my mind a lot. And I don't think it would be if I were not more directly implicated in it. I might be thinking about other things. So I can elevate certain things to worry about late at night.

PF: 31:08 But to be honest, it's the whole schmear that worries me, right? It's like how many patients, for example, are not able to get to their cancer care or their malaria treatment or a bed net? Whatever. How many people have been lost in the course of the last year? How much of that massive excess mortality across the world is due to COVID and how much is due to really a shutdown of access? And you look for happy stories too. For example, in Rwanda, our colleagues-- and when I say our, in that instance, I mean, Michelle's and my colleagues there. I spent the month of August there. Didn't get much done. I don't think they needed me, unfortunately.

PF: 31:57 But when I would go to the hospital and talk to the people - people we'd known for many years - about, "Well, what happened to this patient and that patient?" What I found there was a much better accounting of where people were than I did in the United States, in Boston, for example. You run into a colleague at the Brigham and say, "Hey. What happened to that patient?" We're not going to know. It was just overwhelming. So we had the staff, and we had some of the stuff, but we didn't have the systems, right? And I'm impressed. Rwanda's got some good systems going on, right? So what keeps me up is the whole schmear. How are we going to make sure people stay in school, have jobs, and don't meet the fates that we've been fighting against well before we ever heard of COVID? And I think this is a very concerning problem. It keeps me up at night.

PF: 33:00 And I just want to say one thing back to the question, Dereck, that you asked Michelle about formative experiences. I just want to get it out there that my formative experience, my biggest, best teacher has been Haiti and Haitians. Not just Haiti, its historical example, but my colleagues and patients and friends and family from Haiti. And so once you've had that experience, and maybe you'll ask Michele about it, too, of being corrected by, schooled by, scolded by, trained by the Haitians, it gets in yourself. Your body, your mind, your heart, whatever. And so by the time I went through medical training, I had already been-- when I say Haitianized, I don't have delusions about me being Haitian. I'm just saying I'd already gone through the treatment. Which can be tough at times but mostly joyful and instructive. There are some hard lessons in there.

PF: 34:08

So back to the question of racism and medical training, and again, I appreciate you guys inviting me on this podcast. I'm aware of many things about that. My first book was about AIDS and racism, and I'm sure you read that great bestseller, AIDS and Accusation. Just flew off the shelves. And my colleagues at the Brigham, they're like, "Oh, that's cool. He's written a book about Haiti or something, or AIDS." They would miss the racism part of it and look at the index itself or the way it's set up. My point is, right now-- and again, this is to echo Michelle. My point is, I feel right now that we're at a moment where people are paying attention to things that they should have been paying attention to all along and that people under the boot are obliged to pay attention to all the time. Unemployment insurance. Insurance, in general. Sick leave. Social supports. All of the things that would have improved the lives of countless millions, and billions probably, in the past.

PF: 35:30

And when I say, "In the past," I mean, during my medical training. Which, granted, was a long time ago, but not that long ago. All of those things. You write a book about AIDS and racism and then another one and then a book about TB and racism. I'm just saying it was good for my academic career, but it's not like it was the subject of everyday conversation among my medical colleagues. And, of course, during rounds, when they're asking me for dosing recommendations on antibiotics, they don't want me to give them a lecture called Women, Poverty, and AIDS, right? I got that. But in Haiti, I'd get a much more sympathetic audience. And so I realized going between Harvard and Haiti all those years what that was like. That was also built into me.

PF: 36:16

And now to see more people in the country in which I was born and raised talking about these things, particularly my professional peers, has been uplifting to me. And as Michelle points out, we would hear these questions from our students and trainees all the time. But I'm hearing it across the board. Michelle just wrote a piece on racism in medicine with the chief of medicine at the Brigham, and we're seeing this more and more. So what keeps me up at night is not that. I'm so freaking relieved that this has become a topic of national conversation. I'm pained by the cost that was necessary to be paid. I'm not talking about George Floyd. I'm talking about way back, again and again, and again. But if this can be front and center for medicine, and in education, for that matter, it will be a great thing for the future of our country and I think elsewhere too. [crosstalk].

MM: 37:20

Can I just build on that? Yeah, no, I just want to build on that. I really appreciate that, Paul. I love that arc that you put together. And I think the piece about vaccination, in particular, is just what I'm thinking about. Because I think what you're also saying is the vaccine represents how resources are controlled, extracted, unfairly distributed. And at the same time, what I think is so important is that we can't have vaccine tunnel vision. On the one hand, vaccine nationalism and the Global North hoarding doses of vaccines, right? And literally, even if the money was available, can't even buy enough vaccines for countries in the Global South right now. So there's that. And that's a very powerful mirror for us to look at ourselves and say, "Why is this happening again?"

MM: 38:17

And at the same time, vaccine tunnel vision is going to destroy us, right? If we make this pandemic only about the vaccine and miss all of the social support, the broader context of global oppression, the broader context of global extractive economic policy and capitalism and climate catastrophe, and all of

these things, if we make the only lesson from this pandemic vaccine or vaccine nationalism, even, we've totally missed yet another opportunity to think about the broader construction of society and the world. And so how do we avoid that? I mean, that honestly has been such a big part of what I've learned from our work in EqualHealth's global Campaign Against Racism because that's been one of the central conversations because the conversation is 24 chapters across 10 countries.

MM: 39:12

So it's not a bunch of even Black American doctors who have tremendous privilege. And we don't talk enough about the class position of doctors of color. I mean, we usually talk about the lack of doctors of color in the health professions, and we rarely talk about our class position and how important that is for our self-awareness and solidarity, and how we practice antipoverty in addition to anti-racism. But we can't miss that point, right? We can't miss that opportunity, right? We can't turn to only focusing on this biomedical and technical solution that is both profoundly important, right? Incredibly important to the pandemic response. And yet, if we miss the chance to talk about the broader social contexts in which we're delivering this vaccine and trying to fight, again, these global dynamics and history, then I think we've lost, right? I think we've lost what COVID offers us to learn.

DP: 40:13

Absolutely. I have to ask a follow-up. Because you've both talked about the way our identities change the way we're oriented towards these issues and the way we relate them. And it's something absolutely I think about too. I think about, what does it mean to be-- even when you enter medical school, your future has changed regardless of how much money you have in the bank account [at that minute?]. And I think a lot about, and we've started to have some conversations here, around colorism in academia, as well. Paul, because you mentioned it, you are the first White identifying guests on our show in, I think this would be the ninth episode. And it is because of your books that you've talked about, because of your scholarship in this area is so deep and we knew that there was a tremendous amount we could learn from you on this topic. But I'm wondering if you have any other reflections about how that shapes the way you relate to the anti-racism movement? And if you have any kind of words of wisdom or advice, first for our listeners who might be sort of oriented towards the issue in the same way?

PF: 42:10

Well, I mean, if you have this kind of transnational or transregional, whatever, life, and of course, identity is created for you, as you well know, wherever you move. And so, it's one thing to grow up in rural central Florida. It's another to be a 23-year-old who will end up working in Haiti for decades. It's another to be in Rwanda. But in each of those instances, I'm highly aware of White privilege. And again, I had that really pushed on me by Haitians who I wanted to regard as peers because we were often the same age. And, obviously, friendship is not immune. Meaning, you can hope for those things. Maybe peer is the wrong word. Isn't the right word. But I have been forced to be aware of it.

PF: 43:21

But as Michelle said, there are also other identities that are very strong. Like a doctor, in a place where there are so few of them, there were-- excuse me. I'll just go back to the difficult topic that we've already brought up. That you brought up. You brought up colorism. Michelle brought up class. We're all talking about social disparities. But in those, let's say, first couple of decades, or at least the first 15 years or so, in Haiti working in a rural area, a place

Michelle knows fairly well, which was a squatter settlement, actually. And so there were no non-poor people living there by their own definition. They were non-poor people coming in and out, but not living there. It was a squatter settlement. And who would choose to live there and why one might ask if they did show up. But there was a lot of mistrust of Haitian doctors and some Haitian nurses among the villagers. I mean, routinely. And Michelle saw this, too. So it's not just--they knew she was an American. She self-identifies as Black, and she can talk herself about what the Haitians say to her about that but both of us and I had many, many years of it, have experienced people who trust us more than they do people they would call urban elites.

PF: 44:58

Now, most people when they go to places, you name it, Rwanda, Nigeria, China, wherever, most American students and trainees who go there, go to cities. And I'm just saying most in terms of numbers. But here we are in a rural area where color consciousness is important, but more for historical and far-off reasons. That is, Port-au-Prince. The history of the country. I'm talking about Haiti. But in rural Haiti, really, there was a great deal of focus on class. And I saw it elsewhere in Latin America as well. Much more than I felt that I saw it in Rwanda, Malawi, Lesotho. Again, also in rural areas. But in Haiti, in those early years, it was quite striking.

PF: 45:52

So to go back to your question - which I want to say, Dereck, thank you for the gentle way in which you framed it - I have always regretted whenever I fail to mention my awareness of White privilege. Once in a while, it'll happen in a talk, but it's always in universities. It's very rarely in the hospital or clinic, whether that hospital or clinic is in Haiti or-- there, I'm likely to get teased. Someone will push me on the back of the neck and call me Pink Boy and say, "Look how his skin changes color when you poke it." Little sweet stuff like that, that comes out of living in the same place for three generations. But mostly, there is a deep awareness of class. And this is one of the reasons I keep going back to this material question of staff, stuff, space, and systems, is because anytime we start talking about anything else, a lot of the people who we take care of as patients and who take care of us and teach us will say, "Well, what about housing? What about my daughter's college education? What about a tin roof, rather than a thatched roof?" So that's a third identity. And that one was even harder.

PF: 47:10

I was well educated enough to not think that I was going to end up being a Haitian who looked like the Haitians. I knew a little bit about White privilege when I was 23. I learned it. And then I mentioned class. But there's another identity that is difficult, and that is people who have things that you don't have. And this one is way more significant in my everyday affected life. You get over this hump of not knowing people. Not knowing their language. If you do get over that hump, and it's a good thing to try and do, then you're exposed to another world of want that we know and they know to be related to colonial rule to anti-Black races, specifically. I'm talking about Haiti again.

PF: 48:02

But right now, in front of us in 2021, for example, it plays itself out in other painful ways. And Michelle again mentioned she had the privilege of working from home. But most of the people who we work with and care for as physicians would never think of being forced to stay at home is a privilege, but rather as punishment. So, again, you're so generous Dereck to gently ask the question. I'm saying beyond a knowledge of White supremacy and being able to tell you identify as a White person, there's also class and something quite

different from class, which is, who has the stuff? Who has stuff and who doesn't? And that is that takes up a lot of my affective space.

CO: 49:01

I really appreciated how both of you have really lifted up the places where you've learned and the countries and the people who have taught you. I think that's super important, especially as we want to lift up the Global South more broadly and recognize its many contributions to the world, to medicine, and to public health. And a little bit on that line, we want to talk a little bit about the Decolonize Global Health movement that has largely been driven by medical trainees. I know there is the Decolonizing Global Health Conference at Harvard with the School of Public Health. And it's all about this idea of deconstructing who makes decisions, who is prioritized, and who carries out the work of global health. To start, Michelle, could you talk about what that means to you and how you view it as it relates to the global COVID-19 response? And how do you see this related to the greater anti-racism movement that we're seeing right now?

MM: 49:54

Absolutely. Yeah, no, another phenomenal question. So, I mean, I think it is very easy to talk about it big picture and theoretical kind of broad strokes. But I'm just thinking about what happened the first time that I was leaving the US when I was a medical student to go and live in Botswana for the year. And I think it's a perfect kind of example of what needs to be decolonized because I got literally a 1-hour PowerPoint presentation that was 90% slides of tuberculous bacilli and zero history, right? Now, I mean, I'm a total tuberculosis nerd, so I--

PF: 50:37

In my defense, I just want to say to the podcast, I did not give her that lecture, okay?

MM: 50:42

That was not a Paul lecture, that's true, just for clarification. [laughter] Right. I mean, so there was no history of not only colonialism, which shaped the landscape on the continent of Africa so profoundly, but specifically Botswana, right? I mean, learning about the history of Botswana would have been tremendously important prior to going, right? So the university just did not think about it that way in terms of setting me up. I mean, as a student the other thing that happened was it was very clear that the program that I was going to be a part of was being led by the institution I was coming from with very little input from the institutions in the government of Botswana that I was going to support. The public hospital that I was going to support.

MM: 51:31

And the control of the resources and the grants and the priority's kind of was a big part of that as well. So who gets to set the agenda when its institutional partnerships or government partnerships or whatever it might be, right? I mean, that was clearly Global North arrow to Global South, instead of really following the priorities of the institutions in Botswana. I think we didn't talk about the White savior industrial complex, nor did we talk about the fact that we were so profoundly trained in the biomedical model and not in other psychosocial models. That kind of incomplete education of us as medical students, or as some would say, miseducation of medical students. That wasn't a part of it, right? And yet we have so much we can do to address that and change that and a lot of that's happening.

MM: 52:33

And then I think kind of issues of just medical colonialism. And Fanon is so clear on this, right? I mean, we talk about trust instead of understanding how medicine and the medical-industrial complex can represent the hand of the

oppressor in a way that is so profoundly violent and then we go on and blame the victim. And that conversation about trust and taking HIV medications in Botswana and things like that was all happening in a very colonial framework, to be frank. Even though Botswana was a British protectorate technically rather than a formal colony, but still the same impact in so many ways.

MM: 53:17

And then again, the class consciousness piece, right? A lot of the folks that I was going to work with and for and in solidarity within Botswana were folks who had none of the class privilege that I had. And at the same time, Botswana is one of the wealthiest countries in Africa. So those dynamics, that complexity, that was not a part of my preparation or training as I was preparing to go spend a year in a place that, again, was predicted to be essentially extinct by epidemiologists in two generations because it had the highest prevalence of TB in the world at the time and the second-highest prevalence of HIV in the world at the time. And as I mentioned earlier, a life expectancy of 36 years. So I learned a tremendous amount. And yet I think that experience of what happened prior to me going for that year-- and I didn't even speak about humility, right? That wasn't even on the agenda. It was certainly not a slide in the PowerPoint, right? So I think some of those experiences are kind of maybe concrete examples of what could be in terms of decolonizing global health.

MM: 54:33

But I think that COVID is going to blow a lot of that out of the water. I hope. I hope. I hope. I hope that when we re-engage in global solidarity towards achieving global health equity in new ways in the post-COVID era that those same patterns and mistakes aren't made. And then the last thing I'll say is just that Haiti has taught me so much and shaped my political consciousness so much, and one of the most important ways is that through teaching social medicine in Haiti to Haitian and international health professional students over the years, one of the best projects that came out of it was a video, actually, that our students created called Know Before You Go.

MM: 55:17

And it was just this very short, eight-minute video created by Haitian public health, social work, medical, nursing students and some of their colleagues from around the world basically saying, "Stop coming to our country without even understanding, again, what Aristide demanded in terms of reparations, $21 billion, in the early 2000s. You need to know that before you come to my country." Or what happened during the North American Free Trade Agreement and how it destroyed the Haitian economy. You need to know that before you come to Haiti." So they're all those kinds of examples. And the students, yet again, did it best. But those, I think, are just a few things that come to mind for me.

CO: 56:06

Thank you. I think it's great to highlight avoiding being a parachute researcher, who just dives in and then leaves with whatever information they need. We know that it just really plays into the whole idea of like mono-directional information from the Global North to the Global South, which is what we're trying to avoid. So, Paul, I'll turn it over to you to answer the same question.

PF: 56:25

Well, Chioma, you already know a little bit of my answer, having been in a class with me. And, again, I get to pick up on Michelle's points and say, back before you guys finished your training, when someone like Michelle, the resident, would write all this great medical note and then the attending would come by and write, "Agree with above." So I get to say, "Agree with above." But I'll add in a couple of things. And one is something that's been troubling

me. I've discussed it with Michelle and a few other people, but I might as well say it on the podcast. I get troubled when universities dominate anything. So the real movement to decolonize global health has to be rooted, as you've all said, in a social movement. And the primary protagonists in that movement, I don't think they should be elite academics.

PF: 57:20

And again, that's a lesson I heard from the Haitians back in the 80s and the 90s. Like, "People have to prove themselves to us." And the unidirectional information flow is, as you said Chioma, is a big problem. And the bigger problem, if there is one, is that any time we erase history, we're not going to be decolonizing anything. Because, for example, Michelle was talking about Botswana in a colonial context. But I will bet you that if you look carefully at Botswana's colonial history - and I haven't. But go ahead, look at Malawi, I have. Lesotho, yep. Another protectorate. Certainly, Sierra Leone, Liberia, Rwanda. If you look at them, the colonial context was basically not to give care at all. So there were public health measures, but they were designed to protect the labor force and the investments. And the British were terrible around this, but so were the French and the Germans, and I don't doubt, the Portuguese and the Italians either.

PF: 58:31

So the idea that there was a colonial medical service that provided clinical care to the people who still are called natives, in my experience, in Sierra Leone and Liberia, there was no clinical care. I mean, the British showed up in Sierra Leone at the end of the 18th century, not the 19th century, and they stayed until 1963 or so. And during that long period, guess how many medical schools they founded? Zero. But even as shockingly, how many nursing schools? Zero. So every effort to start a medical school, a university, a nursing school is a blow against colonial rule because those were not littered across that continent any more than caregiving was. It was all about disease control and control over care.

PF: 59:24

And again, I don't know about Botswana, but the real colonial context would not include ARBs. There was no interest. I mean, look at epidemic by epidemic. Sleeping sickness. Yeah, well, they did try that, but they used arsenic derivatives that blinded a lot of people. Mostly, it was the same thing we saw with Ebola. Isolation and let's see if they get better. Treatment centers, isolation centers, all that was common in the colony. Medical care was not. And so what was going on? We know, of course, that colonial rule was never about the fiction of a civilizing mission or anything like that. That's absurd. But it was about extraction, as Michelle said. And the antidote to extraction is reparations. It's like we're taking out a lot more from Africa than information. It's capital, its minerals, its ores, its wood, its people, and it has been that way for a long time. So the opposite of extractive colonialism is some form of reparative action.

PF: 01:00:38

And I think we should just say it. You want to think about slavery and its successor regimes all the way to the end of colonial rule, we should be thinking about reparations as well. And is it going to be controversial? When has it not? 40 acres and a mule led to the rise of the Klan and other White vigilante activities, right? And so, yeah, it's going to be controversial. Now, I happen to not love that, but I mean, we're not going to get around the topic of decolonizing global health by talking about the order of the authors on a scientific paper. But we could if we talk about, "Okay. Who gets to go to university? You and you and you and you. Who gets to have medical care

when they're sick? Oh, everybody.

PF: 01:01:35

So I'm actually optimistic about decolonizing global health, but my optimism comes from shocking developments. Like, suddenly, instead of control over care for AIDS in Botswana, at least somebody's saying, "Well, maybe we ought to treat them." And if you look carefully at those episodes, a lot of the people to object to the lack of cost-effectiveness, feasibility, all that, they weren't Botswanan. They weren't people living in Botswana. They were our peers from universities. So I'm just saying the universities need to play-- the North universities and the big ones in the South, in South Africa or whatever, of course, we need to play a role, but it can't be us in charge. We have to focus on these material demands from the people who have been left out. And that's going to be hard and it's going to be contested by people inside universities, just as they will contest the notion of reparations.

UE: 01:02:36

In the words of my girl [inaudible], that was a word. The antidote to extraction is reparations definitely needs to be the tagline for this pod. But like you said, Paul, we do have moments to be cheerful. This hour that you all have spent with us has been so incredible, and we're so grateful for both of you for your wisdom and knowledge. In that spirit of being cheerful, and kind of acknowledging what does bring us hope, Paul, you alluded to some of your experiences recently in Rwanda. And so, Michelle, I wanted to offer you the opportunity to share a little bit about what brings you hope in this moment.

MM: 01:03:13

Yeah, no, seriously, it's great to be able to end on that note because I think if we can't find the joy in this work, if we can't deepen our relationships with each other and keep lifting each other up and again doing collective care instead of self-care, I think that, again, we haven't learned our lesson. That that is critically important in tackling such issues as big as these are and as longstanding as they are. So I think one of the many things that gives me hope and that I think keeps me feeling inspired is just the fact that global solidarity and anti-racism are accelerating. I mean, that's clear, right? They're accelerating on every axis that I'm looking at. And I think I feel that most deeply within the work that I've been seeing across EqualHealth in our global Campaign Against Racism, in particular, where folks have just come together in all kinds of new ways. I think one of the most inspiring things that happened recently was we had a conversation about the future of Pan-Africanism. New visions for Pan-Africanism. And it was led by two incredible Black women. The two of them led this beautiful conversation about what the future of Pan-Africanism could look like and a feminist future for Pan-Africanism. And that's just not a conversation we would have had if we hadn't had two tragedies that have accelerated global solidarity and anti-racism and racial justice work. So I see that as a source of hope for sure.

DP: 01:05:01

Amen. This has just been an amazing hour, and we talked about so many things. We talked about how we challenge the legacy of imperialism and colonialism and cultural hegemony in our institutions, but also in ourselves, and how we start to and continue to evolve and think about how we decolonize and deconstruct harmful policies that resulted in inequitable distribution of materials. How do we build a paradigm of global solidarity. And so grateful to you, Michelle, for really reminding us how much this exists within the context of global movements for Black lives and that this conversation doesn't happen without the organizers and the folks who work and continue to be on the ground in the streets. I think some of my biggest

takeaways are about this being an opportunity to have an anti-racist COVID-19 response, an opportunity to have an anti-racist vaccine rollout, and an opportunity for new consciousness about our connectedness, the importance of social medicine, and a good reminder, I think, for all of us to approach this work and all of our work with humility and hope. I want to thank my friend, Dr. Alfredo Matteus, consulting on this episode and offering us his expertise. And of course, I want to thank our guests. Thank you for being here with us today.

PF: 01:07:02 A real pleasure.

MM: 01:07:04 Thank you so much.