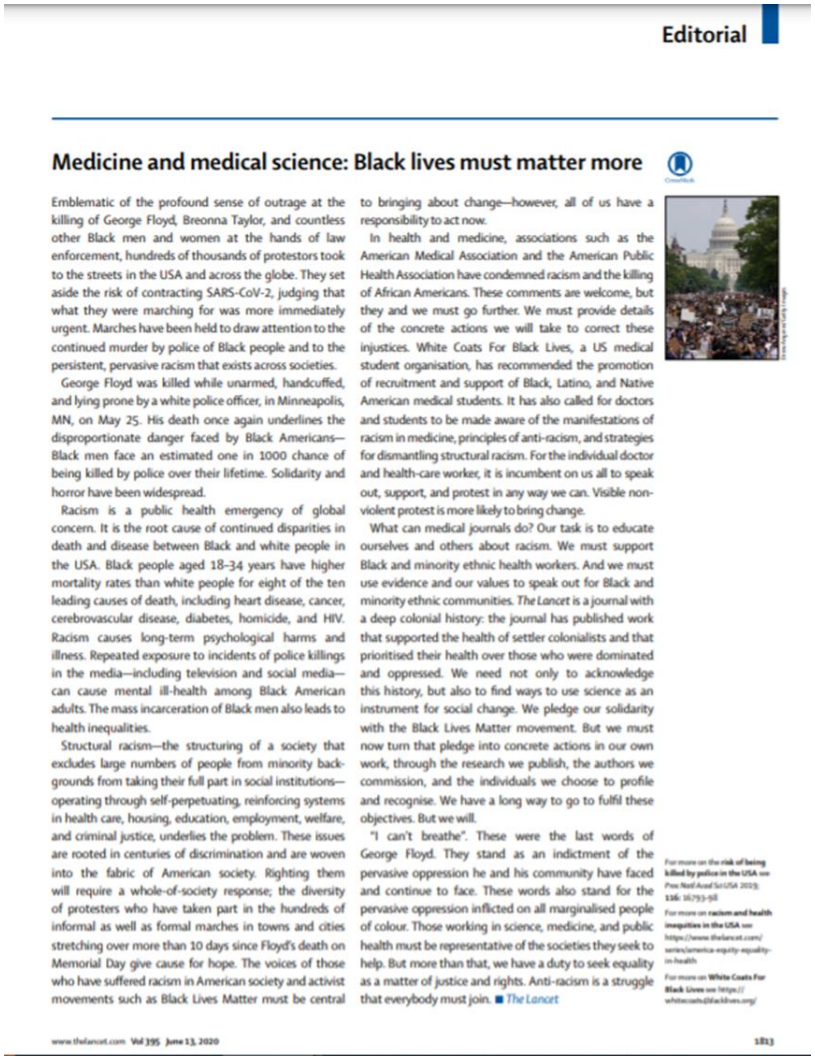
The Lancet Group for Racial Equality (GRacE)



Editorial

Medicine and medical science: Black lives must matter more

Emblematic of the profound sense of outrage at the killing of George Floyd, Breonna Taylor, and countless other Black men and women at the hands of law enforcement, hundreds of thousands of protestors took to the streets in the USA and across the globe. They set aside the risk of contracting SARS-CoV-2, judging that what they were marching for was more immediately urgent. Marches have been held to draw attention to the continued murder by police of Black people and to the persistent, pervasive racism that exists across societies.

George Floyd was killed while unarmed, handcuffed, and lying prone by a white police officer, in Minneapolis, MN, on May 25. His death once again underlines the disproportionate danger faced by Black Americans—Black men face an estimated one in 1000 chance of being killed by police over their lifetime. Solidarity and horror have been widespread.

Racism is a public health emergency of global concern. It is the root cause of continued disparities in death and disease between Black and white people in the USA. Black people aged 18–34 years have higher mortality rates than white people for eight of the ten leading causes of death, including heart disease, cancer, cerebrovascular disease, diabetes, homicide, and HIV. Racism causes long-term psychological harms and illness. Repeated exposure to incidents of police killings in the media—including television and social media—can cause mental ill-health among Black American adults. The mass incarceration of Black men also leads to health inequalities.

Structural racism—the structuring of a society that excludes large numbers of people from minority backgrounds from taking their full part in social institutions—operating through self-perpetuating, reinforcing systems in health care, housing, education, employment, welfare, and criminal justice, underlies the problem. These issues are rooted in centuries of discrimination and are woven into the fabric of American society. Righting them will require a whole-of-society response; the diversity of protesters who have taken part in the hundreds of informal as well as formal marches in towns and cities stretching over more than 10 days since Floyd's death on Memorial Day give cause for hope. The voices of those who have suffered racism in American society and activist movements such as Black Lives Matter must be central to bringing about change—however, all of us have a responsibility to act now.

In health and medicine, associations such as the American Medical Association and the American Public Health Association have condemned racism and the killing of African Americans. These comments are welcome, but they and we must go further. We must provide details of the concrete actions we will take to correct these injustices. White Coats For Black Lives, a US medical student organisation, has recommended the promotion of recruitment and support of Black, Latino, and Native American medical students. It has also called for doctors and students to be made aware of the manifestations of racism in medicine, principles of anti-racism, and strategies for dismantling structural racism. For the individual doctor and health-care worker, it is incumbent on us all to speak out, support, and protest in any way we can. Visible non-violent protest is more likely to bring change.

What can medical journals do? Our task is to educate ourselves and others about racism. We must support Black and minority ethnic health workers. And we must use evidence and our values to speak out for Black and minority ethnic communities. *The Lancet* is a journal with a deep colonial history: the journal has published work that supported the health of settler colonialists and that prioritised their health over those who were dominated and oppressed. We need not only to acknowledge this history, but also to find ways to use science as an instrument for social change. We pledge our solidarity with the Black Lives Matter movement. But we must now turn that pledge into concrete actions in our own work, through the research we publish, the authors we commission, and the individuals we choose to profile and recognise. We have a long way to go to fulfil these objectives. But we will.

"I can't breathe". These were the last words of George Floyd. They stand as an indictment of the pervasive oppression he and his community have faced and continue to face. These words also stand for the pervasive oppression inflicted on all marginalised people of colour. Those working in science, medicine, and public health must be representative of the societies they seek to help. But more than that, we have a duty to seek equality as a matter of justice and rights. Anti-racism is a struggle that everybody must join. ■ *The Lancet*

"What can medical journals do? Our task is to educate ourselves and others about racism. We must support Black and minority ethnic health workers. And we must use evidence and our values to speak out for Black and minority ethnic communities. The Lancet is a journal with a deep colonial history: the journal has published work that supported the health of settler colonialists and that prioritised their health over those who were dominated and oppressed. We need not only to acknowledge this history, but also to find ways to use science as an instrument for social change."

The Lancet: advancing racial equality

"Racism is a public health emergency of global concern. Anti-racism is a struggle all of us must join. We pledge to educate ourselves about racism. We will support Black and minority health workers. We will use the evidence we publish, together with our values, to speak out for Black and minority ethnic communities. We pledge our solidarity with the Black Lives Matter movement. We will now turn that pledge into concrete actions in our own work."

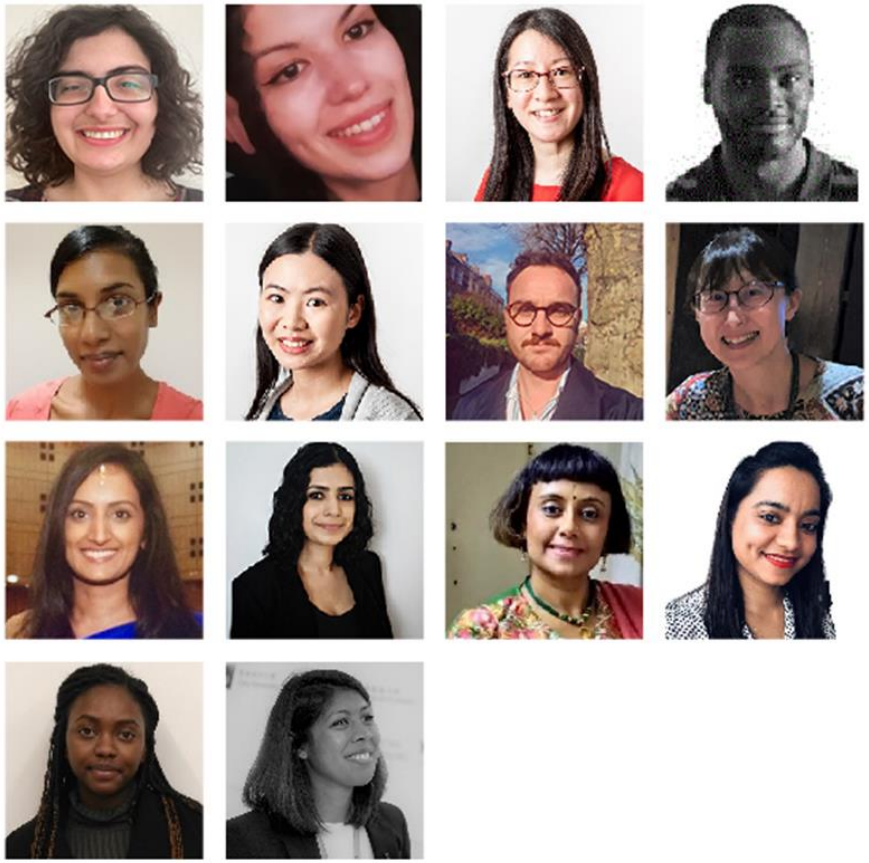
— *The Lancet* antiracism pledge

Our own workplace…

“The optical message for our communities doesn't reflect our values nor our work. The Lancet is also missing out on diverse perspectives.”

“…something that, in all honesty, I personally find unsettling for an organisation operating in 2020, perhaps even more so when working on issues related to the health of people in low- and middle-income countries.”

Our mission



This group will be a space for telling the truth, actively listening, celebrating, and promoting the work of our colleagues, and to turn our pledges into action.

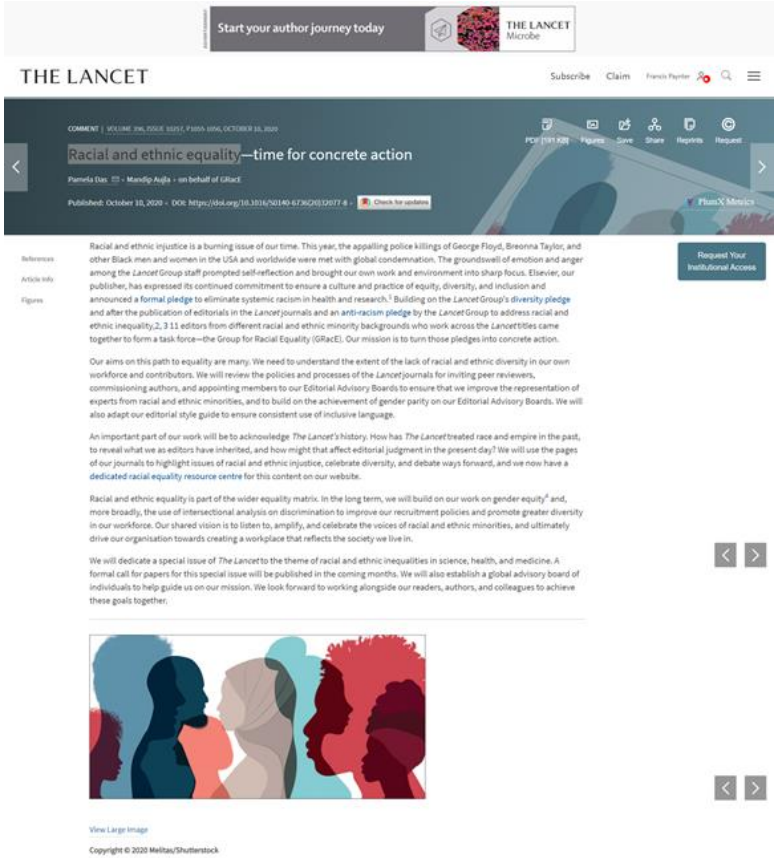
We need to understand the extent of the lack of racial and ethnic diversity in our own workforce as well as contributors.

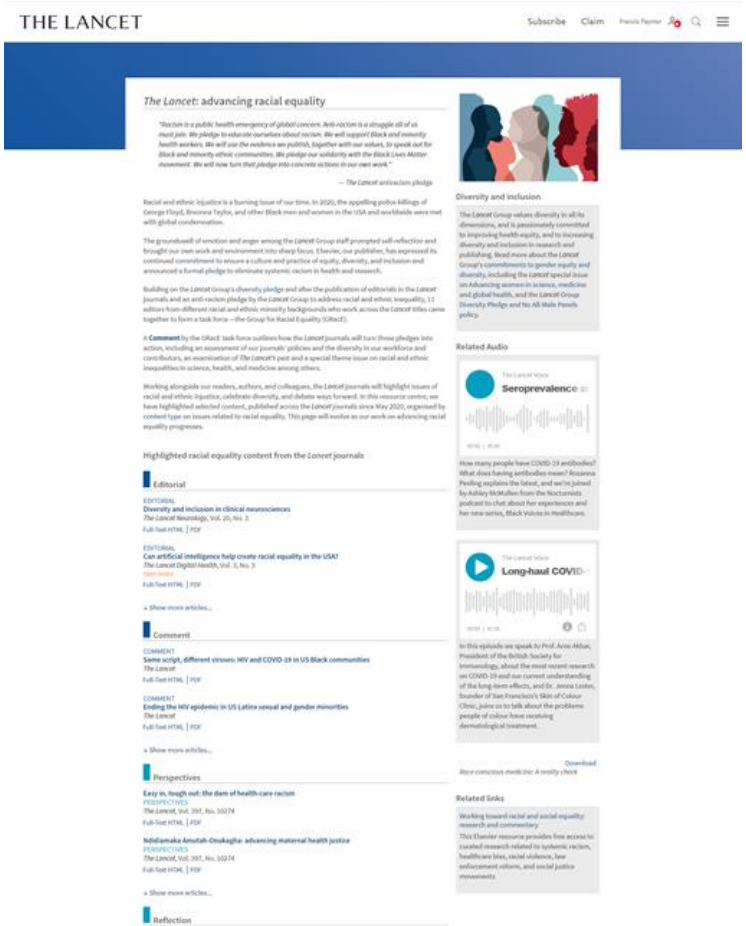
We will review the policies and processes of *The Lancet* journals for inviting peer reviewers, commissioning authors, and appointing members to our Editorial Advisory Boards to ensure that we improve the representation of experts from racial and ethnic minorities.

In the long term, we will build on our work on gender equity and, more broadly, the use of intersectional analysis on discrimination to improve our recruitment policies and promote greater diversity in our workforce.

We will also adapt our editorial style guide to ensure consistent use of inclusive language.

Advancing racial equality in our content





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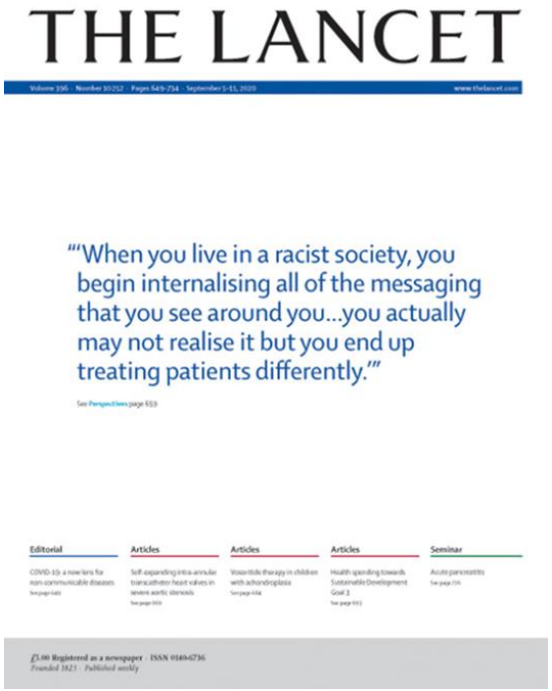
Profiles



THE LANCET

Volume 396 · Number 10252 · Pages 649–734 · September 5–11, 2020 www.thelancet.com

"'When you live in a racist society, you begin internalising all of the messaging that you see around you...you actually may not realise it but you end up treating patients differently.'"

See Perspectives page 659

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Perspectives

Profile

Sharrelle Barber: at the intersection of place, race, and health

Sharrelle Barber's research focuses on the intersection of place, race, and health. As Assistant Professor of Epidemiology at the Department of Epidemiology and Biostatistics and the Urban Health Collaborative at Drexel University Dornsife School of Public Health in Philadelphia, PA, USA, her work has been crucial in assessing the impact of structural racism on racial health inequities among Black people in the USA and Brazil. She sees segregation as a symbol of the economic, social, political, and racial divide in a city: "From Jackson, Mississippi, to Rio de Janeiro, segregation is one of the most visible manifestations of structural racism in our society", she says.

fellow at Brazil's Oswaldo Cruz Foundation in 2016, she led a study in ELSA-Brasil that showed residential segregation could be a structural determinant of cardiometabolic risk factors. Continuing insights will also come from the US NIH US$3·3 million grant she was awarded in 2020 to examine trajectories of changes in neighbourhood environments and cardiometabolic risk factors in Jackson, MI, USA.

New areas of attention have emerged with COVID-19. She is investigating the effects of racism and segregation on COVID-19 racial inequities in Philadelphia and is also part of a collaboration between the Drexel Urban Health Collaborative and the Big Cities Health Coalition documenting COVID-19

Zamaan Fearings

For **Bennett College** see https://www.bennett.edu/

Profile

Kevin Fenton: pursuing equity and equality in public health

Kevin Fenton is a public health polymath. He's worked successfully in health prevention and health improvement for more than three decades and is currently the Regional Director of Public Health England (PHE) London and the Regional Director of Public Health for NHS London. "I have a passion for learning and throughout my career it is about looking for the next set of opportunities to make a difference to the people who I have been called to serve", he says.

Born in Glasgow, UK, Fenton grew up in Jamaica. "My sense of self was really shaped by my Christian upbringing in Jamaica

well as generated data to address the social and structural factors that were placing African Americans at risk", he says.

Insights from the CDC informed his work at the newly formed PHE. As the National Director of Health and Well-being in 2012, Fenton drove accomplishments in tobacco harm reduction, obesity prevention, public mental health, sexual and reproductive health, and screening. He established PHE's health equity portfolio and led national health preven-tion and wellbeing programmes across all age groups. Then, in 2017, he decided to serve as the Strategic Director of Place

Reflections

Cell Systems

CellPress

Editorial

Being Black in the Ivory Tower

This is a moment in American history when the police killing of Black people, and state-sanctioned violence in general, can no longer be ignored or explained away. Lives are on the line, and the urgency of the moment demands and deserves immediate action: on the part of the populace to protest and on the part of the state to reform.

The unavoidable nature of this moment—that it elicits vivid awareness of a fundamental racial inequity, can also surface awareness of other racial inequities. For me, the lack of racial diversity in academic science, specifically the lack of propor-tional Black representation, has returned to front of mind.

temic racism. Many times, I wrestled with the issue of benefit and tortured myself with the question: should I feel guilty for accept-ing scholarships or funding specified for people of color? Preferential treatment of any kind doesn't sit well with the idealist in me. Haven't I, as a person of color, benefited from the status quo? Of course, this reasoning leaves something out: it pre-sumes that the status quo affects all equally and ignores all the ways the status quo has already worked against me and others like me. Consider this: if you are White, the status quo in America is your status quo and was built on hundreds of years of preferential treatment in your favor.

Profile

Nia Heard-Garris: illuminating impacts of racism on child health

"Because it impacts health, of course!", exclaims Nia Heard-Garris, talking of the many conversations she's had justifying her research into the effects of adversity—including structural and vicarious racism—on child health to the medical community. Although the link between racism and health might not seem controversial in 2020, "the medical world has been slow to really appreciate that these social experiences can impact your health", she tells

impact people's lives". Reflecting on what she wishes she could tell her younger self, and indeed those following in her footsteps, she says, "you can be a scholar that has rigorous methods, and uses top-notch analyses and...all of that, and also study things that you think matter and bring people to the forefront". This ethos—that research should inform real change to positively affect people's lives—is at the centre of her work. "Part of the reason I am

Decolonising global health

Decolonising COVID-19

When WHO added Disease X to its R&D Blueprint in 2018, the reality of an unknown pathogen that could cause a serious international epidemic was just beyond the limits of the imagination. 2 years later, at the time of writing this Editorial—the beginning of April, 2020—over 1 million people around the world have been infected with COVID-19 virus and 80 000 people have died from the disease. One-third of the world's population is in lockdown. As the world's most advanced economies struggle to repurpose state and private sector capacity to meet the growing demands on health services, the spotlight is shifting to countries without formal social safety nets or the massive monetary injections needed to bolster their economies.

COVID-19 is yet to establish a firm foothold in low-income nations, but African countries are already feeling the economic impact of the stall in global demand for oil, gas, and commodity products. UNDP has estimated income losses of US$220 billion in low-income and middle-income countries (LMICs) and that nearly half of all jobs in Africa could be lost. This, combined with the potential health impact, could be catastrophic. A Comment published in *The Lancet Global Health* in April found that a rapid acceleration in the number of cases in west Africa, as has been seen in Europe, could quickly overwhelm vulnerable health systems that typically have fewer than five hospital beds per 10 000 population. UNDP has called on the international community to pool resources to not only support the public health response but also to prevent economic collapse in the poorest countries. Similarly, the African Development Bank has appealed for a globally coordinated fiscal stimulus. The UN Economic Commission for Africa's Executive Secretary, Vera Songwe, expressed her disappointment at the global response with a reminder that, "If one of us has the virus – all of us have it."

But with many borders closed and wealthy nations increasingly looking inwards, we are reminded of the asymmetrical power structures that still dominate the largely high-income-country concept of global health and development, and the dangers of the poorest countries being left in the dark as traditional powers shift their focus to the overwhelming problems at home. "The global health model is based in large part on technical assistance and capacity building by the US, the UK, and other rich countries, whose response has been sclerotic and delayed at best", wrote Sarah Dalglish in a letter to *The Lancet* in March. Criticising the established notion of global health expertise being concentrated in legacy powers and historically rich states, she laments that "relatively little has been heard from African veterans of the Ebola epidemics in west and central Africa".

The scientific community has fervently responded to the call for a treatment for COVID-19, with the first results of Gilead's experimental antiviral, remdesivir, due to be released this month. However, in the rush to register trials—over 300 so far—a sinister undercurrent has re-emerged. At the beginning of April, two French doctors sparked an intense backlash over comments made during a live television discussion about COVID-19 trials in Europe and Australia by saying that the studies should be done in Africa first "where there are no masks, no treatments, no resuscitation", reasoning that certain studies on AIDS had been carried out in prostitutes "because we know that they are highly exposed and that they do not protect themselves".

Africa is a continent where the legacy of colonialism is particularly heavy. It is shocking to hear these remarks from scientists in the 21st century, at a time when the work of epidemiologists, infectious disease modellers, public health specialists and, indeed, all health workers, is in the public spotlight like never before. At the WHO press briefing on April 6, Director-General Tedros Adhanom Ghebreyesus responded plainly. "To be honest, I was so appalled, and it was at a time when I said we needed solidarity. These kinds of racist remarks will not help. It goes against solidarity. Africa cannot and will not be a testing ground for any vaccine...The hangover from a colonial mentality has to stop."

Territorial colonialism may have ended long ago but this contemporary global health crisis can serve as a reminder that the colonisation of medicine, economics, and of politics, remains alive. We must reflect on practices that have their origins in 19th century imperialism and replace them with new systems that are rooted in values of recognition, reciprocity, and respect.

■ *The Lancet Global Health*

The art of medicine

Will global health survive its decolonisation?

There are growing calls to decolonise global health. This process is only just beginning. But what would success look like? Will global health survive its decolonisation? This is a question that fills us with imagination. It is a question that makes us reflect on what Martin Luther King Jr saw when he said in 1968, in the last speech he gave before he was killed, that "I've been to the mountaintop...and I've seen the Promised Land." If what he saw was an equal, inclusive, and diverse world without a hint of supremacy, then, that world is still elusive. Similarly, an equal, inclusive, just, and diverse global health architecture without a hint of supremacy is not global health as we know it today.

What we know as global health today emerged as an enabler of European colonisation of much of the rest of the world. It has since taken on different forms—for example, colonial medicine, missionary medicine, tropical medicine, and international health—but it is yet to shed its colonial origins and structures. Even today, global health is neither global nor diverse. More leaders of global health organisations are alumni of Harvard than are women from low-income and middle-income countries (LMICs). Global health remains much too centred on individuals and agencies in high-income countries (HICs).

A future in which global health is decolonised would be one in which there are no longer pervasive supremacist remnants of colonisation within global health practice. But how do we imagine such a world? The calls for equity and justice in global health practice need to be matched with a bold vision of the future. What vision can global health practitioners rally around and work towards? As the struggle for equity and justice continues, those in power are likely to fight back—or respond with evasions, token concessions, and changes in appearance but not in substance. Perhaps, a clear vision of what equity and justice looks like can help global health practitioners overcome such inadequate responses.

To decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level. Supremacy is not restricted to White supremacy or male domination. It concerns what happens not only between people from HICs and LMICs but also what happens between groups and individuals within HICs and within LMICs. Supremacy is there, glaringly, in how global health organisations operate, who runs them, where they are located, who holds the purse strings, who sets the agenda, and whose views, histories, and knowledge are taken seriously. Supremacy is seen in persisting disregard for local and Indigenous knowledge, pretence of knowledge, refusal to learn from places and people too often deemed "inferior", and failure to see that there are many ways of being and doing. Supremacy is there in persisting colonial and imperialist (European and otherwise) attitudes, in stark and disguised racism, White supremacy, White saviourism, and displays of class, caste, religious, and ethnic superiority, in the acquiescing tolerance for extractive capitalism, patriarchy, and much more.

Indeed, supremacy persists in the ways of seeing and assumptions that underpin global health practice. It is a supremacist way of seeing and doing when we entertain implicit hierarchical assumptions—for example, about the headquarters of a global health organisation being more important than its regional or country offices. Supremacy manifests in seeing the big as superior to the small—for example, in the focus on national governments when subnational governments are more consequential and closer to the ground. And supremacy is enacted when a greater value is placed on research by HIC or distant experts than the knowledge of those with lived experience.

Will global health survive its decolonisation? Perhaps. But only if its practitioners commit to its true transformation. A crucial first step is recognising that ours is a discipline that holds within itself a deep contradiction—global health was birthed in supremacy, but its mission is to reduce or eliminate inequities globally. To transcend its origins, global health must

Martin Luther King Jr (1929–68)

The art of medicine

Is it possible to decolonise global health institutions?

In the past year, decolonising global health has gained prominence. Much of this movement has come from students of global health in high-income countries and preceded the recurrence of Black Lives Matter movements after the violent murder of George Floyd. Black Lives Matter and Decolonising Global Health movements have managed to shake schools of global health if not to their core then at least awake. As a reaction schools of global health have made statements about racial equality and have avowed to address racism, increase staff and student diversity, and to train their staff in the art of decolonisation. I have been involved in these processes of decolonisation at my own institution. Yet I also view such efforts critically.

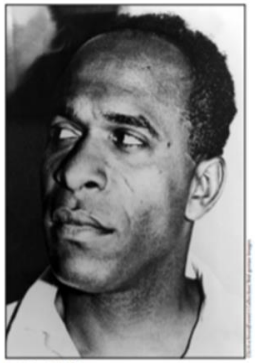
What is it that institutions of global health are seeking to decolonise? What do they commit to when they speak of decolonising curricula and hiring fixed-term anti-racism consultants? Although it is crucial to change the internal structures of academic institutions to combat inequities and advance equality, diversity, and inclusion (EDI), if we want to transform institutions of global health it is equally important to recognise that internal institutional systems were historically designed to maintain overall structures of power. Institutional processes of decolonisation themselves will always be constrained by the imaginations and willingness of global health leadership in high-income countries to bring about and finance sustainable and fundamental change.

To do better and break the cycle of commitments to decolonisation and anti-racism without sustained long-term action to implement real change, it is instructive to consider how decolonisation emerged as a political movement and historical reality. The writings of Frantz Fanon are foundational. Fanon, a Martinican psychiatrist, philosopher, and fighter in the Algerian war of independence, wrote about anti-Black racism and colonial violence and the psychological trauma they caused in both Black and white people before his early death in 1961. I keep coming back to this quote, published in a 1964 translation of Fanon's book *Toward the African Revolution*:

> "Many colonized peoples have demanded the end of colonialism, but rarely like the Algerian people. This refusal of progressive solutions, this contempt for the "stages" that break the revolutionary torrent and cause the people to unlearn the unshakable will to take everything into their hands at once in order that everything may change, constitutes the fundamental characteristic of the struggle of the Algerian people."

To those immersed in institutional processes of decolonisation in global health, some of Fanon's phrasing is familiar. His description of "progressive solutions" and of "stages" will resonate with all those global health practitioners who have listened to leadership plans to implement change. There are differences between the historical contexts of revolutionary action in 1950s Africa and institutional processes in high-income countries in 2021. Yet both are supposedly committed to bringing about the same result: decolonisation. Western powers were reluctant to give up power in the 1950s—political pressure and violent insurgencies forced their hand. If institutional processes of decolonisation today are an attempt to complete the reversal of western political and economic dominance in politics, the economy, and health governance, we have to ask ourselves whether it is realistic to finish in working groups what began through insurgent action. Given the inherent violence of colonialism, Fanon saw the need for violence in overthrowing colonialism in all its forms to free people from white supremacy and internalised racism. I am not advocating violence, but I am questioning whether we will achieve structural change while seeking progressive reform and working through channels that were set up within structures that uphold white supremacy.

Global health's predecessors—colonial and tropical medicine—were designed to control colonised populations



Frantz Fanon (1925–61)

Looking ahead

We will dedicate a special themed issue of *The Lancet* on racial and ethnic inequalities in science, health, and medicine.

We are establishing a global advisory board of individuals to help guide us on our mission.

Formal call for papers to follow.

Other *Lancet* projects in the works:

- Race, health, and xenophobia
- Mental health of black Americans
- Commission on reparations and redistributive justice in the US.

A long road ahead to eliminating systemic racism in health care and academia.

Clearly, fundamental societal change is required alongside stronger institutional policies and commitments within areas of science, medicine, and global health.

Journals are one part of that collective effort – we must be bold, creative and disruptive, and we intend to use the power that we have to drive change…

Thank you

Please contact us if you have any questions or would like to find out more about our work:

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