

WHEN I SAY

When I say ... global south and global north

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I am a researcher from the 'global South' (South Africa) employed at a university in the 'global North' (the UK). While dichotomous terms such as global South and global North are contested,¹ as health professions education practice and research are intrinsically context-bound, these broad meta-categories to signal the complexity of context have pragmatic and epistemic utility.

The global South and global North are not strict geographical categorisations, although broadly speaking apply,[†] with the regions of Africa, Asia, Latin America and Oceania included in the global South and Europe and North America within the global North.^{1,2} Initially, these terms were used to reflect regional economic development differences in the 1980s.¹

Pragmatically, these terms contextualise research, highlighting diversities and disparities, and trigger reflection regarding transferability. To compare my two contexts, the burden of disease, patient population profiles, health practitioner to patient ratios and health care settings and resourcing in South Africa differ vastly from that of the UK. This has obvious implications for curricula content and related competencies of health practitioners.³ 'Best evidence' from the global North may not hold true in the global South^{3,4} as some recommendations may simply be unfeasible to implement and others contextually inappropriate and ineffective.

A recent paper underscores the necessity of these terms from both pragmatic and epistemic standpoints. The paper criticises the global accreditation movement for the 'modernisation', 'standardisation', 'internationalisation' and 'globalisation' of medical education as a form of 'Westernisation' and neo-colonialism.⁵ This global recommendation not only fails to take sociocultural differences in health care and education practices into account,⁵ revealing an erroneous one-dimensional understanding of knowledge and transferability as objective, universal and generalisable^{2,3} but also pushes the idea that the 'West is best' in comparison with 'low-quality' medical education in the rest of the world.⁵

The definitions of global South and global North need to be expanded from their initial economic descriptors to the geopolitical relations of power,² revealing the root cause of said economic differences. The North–South divide is rooted in racism and the history of colonisation.^{1,3,4} Modern medicine is a colonial artefact as it is embedded in Western science and White male perspectives.^{2,4} To draw on postcolonial and decolonial perspectives, the global North represents Whiteness and Western-, Euro- and American-centrism with the global South seen as the 'other'—deviant to the hegemonic 'norm'—as illustrated in the global medical education accreditation critique.⁵

This global knowledge hierarchy can be observed in the continued domination of health professions education research outputs from the global North, including the United States, Canada, the UK, the Netherlands and Australia.^{2,3} In contrast, research from the global South is 'othered'—the researchers seen as non-experts, their knowledge localised and their findings inconsequential, invalid and irrelevant to global audiences—and thus excluded.^{3,6} This denigration of indigenous knowledge systems and epistemologies from the global South is referred to as 'epistemic violence' and 'epistemic injustice'.^{2,3,5} The geopolitics of knowledge and knowledge production is rooted in intellectual imperialism, as the global North controls who is allowed to

*See Khan et al (2022), Table 1, for an outline of dichotomous terms used in global health literature; their origins and potential concerns (e.g., *Who defines? How do we define 'rich' or 'developed'? Rich in what (finances, culture, expertise, etc.)? What about the poor in rich contexts? Why are some contexts 'resource-constrained' and what are the historical underpinnings or root causes?*).

[†]See 'The Brandt Line' for the geographical division between the global North and global South in Khan et al (2022), Figure 1. Examples of exceptions are as follows: Australia is located in the global South yet part of the global North due to its economic wealth and White ethnic majority; the Middle East, while in the global North and economically wealthy, is considered part of the global South, yet some countries in the global South, such as China, India and Brazil, due to evolving economic power on par with countries in the global North, remain classified as part of the global South.

speak and whose voices are legitimised and considered authoritative.^{2,3,5}

Epistemically, the terms global South and global North sensitise readers to the 'location' of knowledge production and encourage the development of critical consciousness by questioning implicit and unchallenged assumptions about these locations and their knowledges—what is considered valid and by who?^{2–4} When undertaking research, 'locate' the literature, theories and methodologies you use⁴ and reflect on what 'ideological baggage' may be attached.⁵ These terms are instrumental in contesting colonial legacies, decolonising knowledge systems and promoting epistemic justice by amplifying marginalised voices from the global South.³

However, it is crucial to recognise that within these meta-categories, there exists a wealth of diversity and nuance, including differences in national identity, history, politics, society, culture and language.¹ It is essential not to oversimplify or homogenise these complex distinctions, as doing so can perpetuate harmful stereotypes and false dichotomies.¹

In conclusion, while the use of terms like global South and global North is not without its challenges, ignoring the practical differences and epistemic heterogeneity and hierarchy they signal is not a viable option.¹ Instead, we should use these terms thoughtfully, being aware of the potential negative, and false, connotations associated with these terms, through interrogation of our unconscious bias and positionality in the knowledge/power hierarchy. The goal is for collective action towards a more democratic, emancipatory, balanced and bidirectionally flowing knowledge system, with contextually appropriate applications.^{2,3} One way this can be achieved is through transformative North–South dialogues and diverse research teams.^{2,3} This heightened awareness, both pragmatically and epistemically, can lead to more equitable and just health professional education, research and outcomes worldwide.

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