LETTER TO THE EDITOR

To be seen, heard, and valued. Active engagement as the next frontier for global health conference equity: a view from the global South

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DOI: 10.4081/jphia.2023.2810

Dear Editor,

'It is the one who lives in the house who knows where the roof leaks' ~African Proverb.

As a Global Surgery researcher in Rwanda, I have lived experience of the challenges to conference equity, having spent for example in one instance, 14 h at an Embassy's visa processing station to get to the World Health Assembly, and losing two opportunities to present at international Global Health meetings as a result of visa delays in the past one year. I experientially understand the cognitive load that barriers to equitable access to conferences place on Global Health practitioners from similar contexts. So far, the Africa Center for Disease Control's Annual International Conference on Public Health in Africa has been an accessible conference, and needs to continually be so-keeping its sights on conference equity to as it pursues its mission to 'strengthen Africa's public health institutions' capacities, capabilities, and partnerships to prevent, detect and respond quickly and effectively to disease threats based on science, evidence-based policy, and data-driven interventions and programs.' As we look towards the third International Conference on Public Health in Africa, the concern of equity must be brought to the fore.

Global health conferences significantly influence globalization and health, as they serve as a hub for policy decisions, networking, and dissemination of new information that enhances provision of health care for local and global populations. Researchers from the global South are actively engaged on global health frontlines, but much is left to be said of their active engagement at international global health conference decision tables (1). Many from Africa are 'losing their seats at the table' to visa delays and restrictions, travel costs, political barriers, discrimination, and racism (2-4). Many times, like pawns on a professional chessboard, they are often engaged forward to initiate the game, while the back row of largely privileged kings, queens, knights, and nobles meet to decide their fate. Gladiators wrestle in the arena, but booth spectators decide between the thumbs up and the thumbs down. Conference equity has been defined as the 'attainment of an equitable level of attendee active engagement, influence, and access to a conference, regardless of country of origin, location, available funds, or affiliation, through the mitigation of known barriers and enhancement of efficacious facilitators' (3). While more and more individuals are paying attention to conference access as a component of conference equity (2), less evidence is available that attention is being paid to the domain of active engagement and speaking opportunities for practitioners from the global South at conferences outside the African continent. Project teams, conference organizers, and individuals need to promote facilitators and mitigate barriers to active engagement for participants from the global South at Global Health conferences (3). While barriers to global health conference attendance are increasingly being identified and challenged (2), it is obvious that just arriving at a meeting is not enough. These researchers 'know where the roof leaks' and should be actively involved in global health conferences (3).

Active and passive engagement-two sides of the same coin?

Active engagement is, in its basic form, *doing* something. Passive engagement, on the other hand, is having *something done to you*; for example, sitting through that global health conference, or watching a global surgery convening livestream. While there is undoubtedly educational benefit to sitting through a global health gathering, Edgar Dale's cone of experience suggests that people generally learn less of what they observe than what they directly and purposefully experience (5). Global south researchers must be given opportunities to actively 'do' global surgery conferences.

Engagement at global health conferences is best conceptualized as a multidimensional phenomenon, on behavioral,

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Key words: conference equity, global health, conference, active engagement

Table I. Ideas for promoting active engagement for Global Health practitioners from the global South at international Global Health Conferences.

	Global Health Project Teams	Global Health Conference Organizers	Global Health Conference Attendees
Long-term, Pre-conference efforts	Capacity building for high quality output Equitable inclusion in research Equitable representation on authorship, and acknowledgement of contributions	Selecting appropriate locations (most globally accessible, low visa barriers, non-distracting, geographical locations relevant to conference focus) Thoughtfully diversifying organizing committees to improve representation Collaborating/building relationships with country governments to help lower political barriers to conference access	Longer-term planning for attendance to minimize distractions around funding, accommodation, visas, and travel
Pre-conference efforts	Deliberately targeting relevant and interesting conferences	Being conscious of, and objectively assessing barriers and facilitators to conference equity Funding travel through scholarships Funding support for accommodation Ensuring early dissemination of visa support letters/visa accompaniment Considering presentation quotas Carefully assembling speakers based on expertise, gender, gaze, pose, race, and country of origin	Deliberately targeting of relevant conferences Submitting abstracts Applying for speaking opportunities Proper planning for logistics to minimize distractions during conferences
Conference efforts	Putting in place accountability measures for team members attending conferences (mandating tweets, session summaries etc.)	Promoting a sense of belonging and supporting emotional engagement by ensuring logistics are well organized for individuals from unfamiliar contexts (airport pick-up and ground transport, feeding, accommodation, internet access etc.) Ensuring panel and presenter diversity Employing engaging pedagogy and variety in presentations	Advocating for equity in opportunities for engagement at the conference (through feedback, comments, and discussion sessions), and publicly celebrating conference equity Advocating for equity in opportunities for engagement on social media, and publicly celebrating conference equity Deliberate cognitive engagement
Post conference efforts	Receiving reports from team members concerning their participation Holding post-conference 'step-down' events facilitated by conference attendees on the project team	Conference equity audits Soliciting feedback and responding to critique	Providing sincere feedback on engagement

emotional and cognitive levels (6). Behavioral engagement speaks of the attendee's level of participation in learning by sharing thoughts and experience, presenting posters and abstracts, giving talks, and leading sessions. Cognitive engagement speaks of the attendee's self-regulation of understanding through thought, experience, and the senses. Emotional engagement refers to the attendee's emotional reactions to presenters, other attendees, and to the conference environment. This includes having a sense of belonging, value, and identity, alongside dynamics of the participant's level of interest, happiness, sadness, boredom, and anxiety (6). While mental action or inaction at a conference (on or off the podium) is largely self-motivated, cognitive, behavioral, and emotional engagement can be facilitated or hindered.

Radio lovers can relate. You can play music in the background all day and passively engage the melodies while eating, sleeping, driving, studying, drawing, or cooking. But when you hear *your* song, you turn up the music and think about the lyrics or the prom in active cognition, you tear up or smile with active emotion, and you sing and dance in engaged behavior. Going to the conference is putting on the radio. Active engagement by attendees can only be achieved by changing the song.

Not only are global South researchers often 'stuck in the middle' of authorship (7), they may also be 'silenced at the bottom' 39 percent of conference attendance (3). Looking around during a *not truly global* Global Health conference focused on Low- and Middle-Income Country (LMIC) issues kills emotional engagement. Jumping through unnecessary visa hoops and negotiating high political barriers before getting on a plane for a conference is draining. The resultant anxiety and diminished sense of belonging discourages engagement (8). The psychology of location may play a role in perpetuating this inequity of active engagement. The loss of context and cultural connect, when we talk about LMIC problems outside an appropriate context, douses vibrancy. On top of that, 29 different publications suggest that limited speaking opportunities for global South experts kills behavioral engagement (3). Historically, high submission rates contrast low acceptance of LMIC first author abstracts. In fact, some research shows that even after acceptance, abstracts from the global South are often less frequently scheduled for oral and poster presentations (3). Some may argue that this reflects the quality of submissions. Looking deeper, we would rather argue that it reflects the quality of capacity building. If output from these researchers is not presentable in LMIC-focused conferences, there must be a defect in accompaniment.

Promoting active engagement

Active engagement for participants from the global South is a fine dance between project teams, conference organizers, and attendees (Table I). The framework should begin with a stronger focus on capacity building on individual, institutional and systems levels during non-national and externally funded global public health projects to improve the research output (9). Equitable inclusion of LMIC researchers in Global Health research is important to bring them to the table and give them a voice.

Attendees from the global South on their part should advocate for equity and stay cognitively engaged, regardless. Organizers should actively facilitate attendance via travel scholarships, accommodation assistance, and visa accompaniment to give attendees a sense of belonging and aid emotional engagement (4). It is important to hold conferences in the sites of 'most relevance and least resistance', but we must go a step further. We should focus on mitigating limitations to behavioral engagement through panel diversity, equitable engagement of LMIC participants in conference organization, and presentations. Conferences should embrace inclusive planning, with the diversification of organizational panels to include workers in the global South in addition to ensuring a non-tokenistic, broad based representation of presenters (including patients and community health workers) (3). The smart carpenter always asks the owner of the house where exactly the roof leaks.

However, there is the real risk of tokenism vs. actual diversity in active Global Health conference participation (10). The symbolic and perfunctory practice or policy of admitting an extremely small number of LMIC participants to an international Global Health conference to give the impression of being inclusive, when in fact they are not welcome, not genuinely empowered, and not given the genuine opportunity to be heard must be mitigated. Throwing in a few speakers from sub-Saharan Africa or Latin America to a Global Health conference to give an outward appearance of inclusion will never be enough. Keeping 10% of slots on a conference for speakers from sub-Saharan Africa is not a sufficient first step. Each one of those LMIC participants can feel tokenized by organizations if they allude to lowered standards when their representation and engagement is encouraged.

In conclusion, sitting through interesting Global Health conferences is not sufficient to influence policymaking in Global Health. An unknown wise man, in defiance of passivity, once said, 'If the *glutei* are numb, the brain is the same.' Research teams, conference organizing committees, and attendees all have unique but interrelated roles to play including pre-conference capacity building, peri-conference accompaniment, active non-tokenistic inclusion during events, and post conferences. After we take away political barriers, financial barriers, and visa restrictions, we must still recognize and wrestle with the question of engagement-because being present at an international Global Health convening is *not* the same as being heard.

Acknowledgments

The author would like to acknowledge Lotta Velin for her review of the concept draft. BA is supported by the Fogarty International Center and National Institute of Mental Health, of the National Institutes of Health under Award Number D43 TW010543. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Funding

None.

Availability of data and materials

Not applicable.

Contributions

BTA, conceptualization, investigation, resources, writing-original draft, writing, review and editing, visualization, funding acquisition.

Ethics approval and consent to participate

Not applicable.

Further information

BTA is part of the Equity Research Hub, a group of researchers who 'aim to quantify inequities in health, identify barriers and facilitators to achieving equity, and develop tangible evidence-based solutions.' This manuscript has not been presented at any conferences.

Conflict of interest

The author declares no potential conflict of interest.

Accepted: 1, August, 2023; submitted: 27, July, 2023.

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