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Decolonizing Global Health

Ibrahima Socé Fall, WHO Assistant Director-General for Emergency Response and UN Under-Secretary-General. Interview done on November 9, 2022 with Mame-Penda Ba (Political Science, Université Gaston Berger de Saint-Louis, Senegal) and El Hadj Mbaye (PhD, Public Health, Université Gaston Berger de Saint-Louis, Senegal).

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Ba and Mbaye: Thank you, Dr Fall, for accepting this interview. The first question is about your career trajectory: how does one become Assistant Director-General of the World Health Organisation (WHO) when one's name is Ibrahima Socé Fall?

Fall: Oh, that's a complex question because my trajectory is not linear. I knew very early on that I wanted to be a medical doctor and that there were no other options for me. As a child, I had an allergic condition and I would go to the doctor's office regularly. Two doctors particularly impressed me in Rufisque where I grew up, Dr Lamine Dieng and Dr Cheikh Dieng. I had the greatest admiration and respect for them. They symbolised knowledge, culture, charisma and the most noble and socially useful profession for me.

At a time when best students were in public schools, I was lucky to have excellent teachers, both in primary and secondary schools, that gave me the desire and motivation to become a doctor of medicine. I had excellent teachers in biology and natural sciences. And when I passed the Baccalaureate exam which gives access to higher education - at that time you had to fill in guidance sheet to choose the field of study to follow - I had to choose three fields of study in order of preference: I chose medical studies for all three options. I didn't even want to consider the possibility of doing anything else. In fact, in my final high school year, at the same time as I passed the Baccalaureate, I took and passed the entrance exam for the Military School of Health (École militaire de santé) where I was trained.

At first, I didn't go into public health, I wanted to do internal medicine, which I was very passionate about, but I didn't really fit into the bureaucratic culture in internal medicine departments. So I switched to surgery. I started to do surgery at the Hôpital Principal in Dakar where I was always in the operating room with senior doctors such as Dr Gorgui Diaw, who taught me the rudiments of surgery, which helped me a lot later on when I was in the field. And when I finished my medical studies in 1992, the conflict in the region of Casamance was in full swing and I was sent there for two years to support the troops. After that mission, I was sent to Marseille for training in tropical medicine and epidemiology at the Institute of Tropical Medicine of the Army Health Service (IMTSSA), a school that had preserved all the heritage of the French army's tropical medicine. This was in 1994-1995. It was there that I began to study in depth the epidemiology of infectious diseases and the fight against emerging and re-emerging diseases. Despite this, when I returned to Senegal, I still had in mind to continue with surgery but the army had already seconded me to the Ministry of Health and I was sent to Podor to work with the Great Endemics' Service and also to be in charge of the health district. It was during this period that I started to spend a lot of time in the villages, and I realised that medicine was very vast and that there were many things to do. That's when I put surgery aside and decided to go into public health permanently. I then had the opportunity to participate in a WHO international course on malaria control in Cameroon. I left Podor in rather complicated circumstances and when I arrived, it was already the end of the first module on epidemiology. The exam was to be done two days later. When we took the tests, I had the best mark in epidemiology. People were asking "how is that possible?" but in fact I had already done epidemiology in Marseille, and I already had field experience in Podor. At the end of the course, I had the best results and the WHO team started to follow me and then progressively asked me to do missions from 1998-1999. At that time there was the African Malaria Initiative. And when the Roll Back Malaria programme was launched in 1998, they had to find experts to go and conduct situation analyses in different countries and prepare strategic plans etc. I was co-opted to be part of the group of experts that started Roll Back Malaria. I was the youngest in the group. For me, the missions were really moments of discovery and learning in the field. While doing that, of course, I continued to work in Senegal. After Podor, I came to Diamniadio to open the Elisabeth Diouf Hospital before I started teaching public health at the university level.

When WHO offered me a job, I really didn't want to leave and I stayed two weeks without answering the message I received. I was an assistant professor at the public health department at Cheikh Anta Diop University (UCAD) and I didn't want to leave for a long period of time. I applied for a one-year leave of absence, but the Faculty Council was slow to decide. At one point, I said to myself, "Why not try?" I knew I had a lot to learn there. I resigned and finally left, I wanted to stay for one or two years but I was so committed that it took me longer.

Throughout my career at WHO, I have remained focused on professionalism and science to get ahead. Being professional, always looking for solid knowledge and real experience in the field. It is with this conviction that I have evolved at WHO, without any particular support except that of my wife and children, relying only on my own efforts and the confidence I had in myself because it is important. Confidence is part of my C-list. I have a long list of Cs to develop not only in international bodies but also everywhere really. The first "C" is the search for competence from knowledge. It is clear that we have to make a difference between knowledge and information because often we have access to information, but not to knowledge, and it is mainly knowledge that we can mobilise to make good decisions. The second C is courage. Without courage, we cannot progress in this system or in life in general. Courage to go beyond one's own limits, but also the courage to say no when it is no, to say yes when it is yes, and the courage to acknowledge one's mistakes. The last C is to work with a lot of compassion and justice, to work with the heart, because it is with the heart that you can really go beyond some limits. It has not been easy because when working in an international environment, you have to be tough. The reasons why we are at this level, whether it is me or other Africans who are in leadership positions in international structures, is because of the work we have done that is recognised at the global level.

Ba and Mbaye: You say that you have dreamed of working in the health sector since you were young, but for a long time it was in the context of one country, Senegal. When did you start dreaming to work for Africa?

Fall: The dream for Africa came when I was involved in the fight against malaria, when I started travelling in Africa and seeing what was going on everywhere, in international meetings on malaria. I was struck by the fact that when we called the East African countries, for example, it was the English specialists who came to make the presentations, and it was the same almost everywhere. I said to myself no, this is not possible, something has to change. I started to go around the countries to organise training activities in the fight against malaria. I was already training people in Senegal when I was on the steering committee of the Malaria Control Programme. I used to go around the health districts to train nurses, midwives and doctors. For me, it was essential to train a critical mass of Africans who would speak for Africa. And that's why I stayed longer than I expected.
The same thing happened in Guinea during the Ebola epidemic. When I arrived in the worst affected areas, most of the coordination was done by young Europeans. I said to myself that this had to change because Africans had to really take charge of this epidemic. So I did the same thing again, this time for Public Health Emergency and Epidemic management, i.e. training a critical mass of young, very competent public health professionals. Afterwards, I continued to train many people in Africa and to deploy them within the framework of South-South cooperation so that the Guineans could go to the Congo, the Senegalese from the Pasteur Institute in Dakar could go to Angola for yellow fever, etc. So I have evolved with this idea of decolonizing global health by having a significant of African capacity to perform the work. Of course, we are not opposed to collaborations, but there must be African leadership. Africans must take charge of their own health problems.
That's why my dream is to come back to Africa, to work with Africans to build institutions that will have their role in global health, whether it's in leadership in the management of health policies and programmes, in the preparation and response to epidemics and pandemics, in the field of research, capacity building, etc., because I find that Africa has a great potential, with its young population. Already, by relying on the young researchers and epidemiologists that we have trained, there is a model to scale up. During the colonial period, a lot of things were done in terms of pharmaceutical testing without respecting norms, human rights, and many other things also happened. Then we experienced a partnership that was not fair because there were many institutions and researchers who came and whose only interest was to collect samples in Africa. Afterwards, they would go and make their publications by associating the Africans who are satisfied with that. We have to go beyond this stage and come back to the expression "decolonization of global health", which means that Africans have to define research priorities, invest in research, carry out their research within the framework of ethical partnerships, publish it, present it to the whole world, but above all improve the health of their population.

Ba and Mbaye: You were the head of the Ebola Emergency Response Mission in Mali and when you announced on television that the Ebola epidemic in Mali was over, we all had the feeling that we were living a historic moment. What did you feel at that moment and what finally allowed you, after a fairly short period of time, to be able to declare that an epidemic is considered over in a country?
Fall: At that time, I was clearly driven by a sense of pride, because you have to remember the context. We were still in the middle of the great epidemic when many countries (Guinea, Liberia, Sierra Leone) had been affected for a long time and had not managed to control it. In Mali, it was important to demonstrate that the epidemic could be controlled despite the outbreak in the capital, be it only to restore confidence in other countries. The context was also that there was a lot of politics involved because when the United Nations Mission for Ebola Relief (UNIMEER) was set up, there were a lot of problems in the countries, a lot of people from the UN were parachuted in, everything was turned upside down and Mali was the only country where a WHO representative - in this case me - was leading the mission. It was vital that we showed that as Africans we could manage this epidemic, because there were all sorts of attempts by some countries. Then when these same countries saw that things were going well, they tried to position their nationals. We had to remain calm and focused on the objective, coordinate the work and put in place an effective system. For six weeks at least I slept three hours a day, I left the office around midnight, slept three hours and was already functional to work again. It was a lot of accumulated fatigue and in the video it was a relief to be able to say that the epidemic is over.

Ba and Mbaye: But what were the recipes for overcoming this Ebola epidemic in Mali? A lot of work? Coordination? Serenity?

Fall: In fact, I started by taking the lead even before the epidemic broke out in Mali. We got the information about the epidemic in Guinea on a Saturday in March 2014. I was returning from a trip and when I got off the plane, I heard on Radio France International (RFI) that there was an Ebola epidemic in Guinea. I called the regional office, they confirmed it and on Sunday I had the first meeting of my team with that of the Minister of Health. On Monday we had the first inter-sectoral meeting with about fifteen ministers. So we started to invest in preparation and coordination. This anticipation was important, but despite this, when the first cases occurred in Bamako, even the Ministry of Health panicked; they no longer wanted to communicate the key elements in a transparent way. We were invited on television. The advisers of the Ministry of Health did not want to be clear about what was going on. I rose and said: "Stop playing,

this is serious. We have an Ebola outbreak in the capital. We have to defeat this epidemic as if we were in war or lose it like other countries ". It was a live broadcast, the journalist wanted me to confirm my words, I told him "Sir, I am not playing with words, I am serious". And the next day, it was the President of the Republic who called us. He started to listen, to take decisions, and therefore to mobilise the leadership and the population. This programme was crucial. If we had missed this opportunity to tell the truth, it would have been the end of Mali and perhaps of other countries in West Africa. So for me the key elements are preparation, efficient coordination, a sense of responsibility, community involvement - we worked with all possible groups at the community level (religious, women etc.) - and political involvement at the highest level, that of the President for certain decisions..

Ba and Mbaye: What has Africa been able to demonstrate and capitalise on in the fight against epidemics, be it malaria, Ebola, cholera, Covid today; that we can share with other countries?

Fall: Africa has learned a lot from the Ebola outbreak in Guinea. The WHO has done a lot of very intensive training in field epidemiology. Today, we have thousands of young researchers and doctors who have been trained and who are deployed all over Africa and even elsewhere. We have young people on the American continent, in the Mediterranean and Arab regions.
Furthermore, in Africa, we have become very good at contact tracing, i.e. the investigation and follow-up of contact cases. When the Covid epidemic started, the European countries that were always criticising the work that the WHO teams were doing on contact tracing as soon as it got below 90%, were themselves overwhelmed. After a few thousand contact cases, they could no longer keep up. In the UK, for example, when they had to track 3,000 contacts, their system broke down, whereas we were tracking hundreds of thousands of contacts in the war zone. This is why I said in several interviews with the major media such as Le Monde, CNN, etc., that for everything that concerns field investigation, field epidemiology, the best are today in Africa because we have simply invested in training and research during all these epidemics.
Secondly, when it comes to epidemic response models, it is important to remember that Africa faces more than a hundred epidemics every year. The continent has response models in place that work. Africans can teach the rest of the world innovative strategies, devices and practices on how to prepare for and respond to epidemics and how communities can be resilient and adapt to complex situations.
All these lessons learned, all these experiences, are capitalised on when new emergencies occur by making new decisions based on evidence. We always adapt the response to the new knowledge we have. It's a very dynamic job.
If we have to go back in time, we should also remember that it was us who changed the way the global malaria report was done. And this was a work that I initiated with my colleague Dr Noor from Kenya who was working at the time with a Kenyan institution, Kemri (Kenya Medical Research Institute). We showed that you can't make reports just on the basis of reported cases. We did a ten-year study on the real endemicity of malaria in Africa and the changing risks, which showed the exact situation in Africa. We published this in *The Lancet* and from that the global malaria report was improved.
It's the same thing with strategic planning, we developed tools that were eventually used all over the world. Everything that is done on strategic planning, performance management in the fight against malaria has been done under my coordination, with my team. I am sure that there are other Africans who have other experiences. So we need to have this scientific contribution at the highest level and be able to influence what happens.

Ba and Mbaye: Given all this, why is the experience of Africans not sufficiently valued? Why does Africa find it difficult to show its strengths in the medical field but also in the field of public health in general?

Fall: It is up to Africans to promote themselves, no one is going to do it for them. It is a question of presenting the work that we have done and that we are doing. We need to have a significant number of people who are really able to present serious work at world level. We don't have that number yet, but it's progressing, there's a lot of things being done, but we need more investment and we shouldn't just wait for the partners to come and do it for us. If we - Africans, our governments, our private sector - really want to decolonise health, we need to invest in health research, in our research priorities, in certain diseases that don't exist anywhere else. We talk about neglected tropical diseases, that's a very pejorative term, why are these diseases neglected? It is up to us to invest in this research, in the training of young people in all areas of health so that our doctors and researchers can compete with their colleagues around the world. I think that it is this work, which has been initiated in many areas, that must be reinforced and continued. I see with great hope the young epidemiologists who are now making their mark in their field. When we look at the development of vaccines and clinical trials, for example, we have young researchers like Dr Alhassane Touré and Dr Abdourahamane Diallo from Guinea, who come here to Geneva to present quality research. They are team leaders in cutting-edge fields, they were part of the global research team on the Covid vaccine after Ebola, and they are currently in Uganda for vaccine research against the Sudan strain of the Ebola virus. These are concrete examples of how we can train our health workers and researchers to meet global standards. Less than ten years ago, this expertise did not exist, but now Africans are references at world level. When an epidemic emerges, they are the ones who are deployed. This must now be scaled up and these human resources must also be developed in their own countries. There is a concept that I am currently working on with my team called

the Global Health Emergency Workforce. Its African component is essential. In each country, we must be able to develop capacities and expertise in the field of health. We must have teams that work together and propose to the world another way of doing things in the fight against epidemics and emergencies, in the purely biomedical, epidemiological and socio-anthropological fields.

Ba and Mbaye: And in terms of scientific publications, what has been Africa's contribution to a better understanding of and response to these epidemics?

Fall: This morning, I was thinking about what I used to do with my team when I was in Africa, we had our weekly newsletter on epidemics and health emergencies. Each week we produced between five and seven in-depth articles on current epidemics and emergencies. In less than three years we have published over 500 articles. I still wonder why we haven't decided to value it as an epidemiological bulletin for Africa. I think it is urgent and important to set up a public health journal because this is also something that is missing. It is quite paradoxical because today the best publications on Ebola - in the most respected journals such as *The Lancet, Science, Nature* or the *New England Journal* - are made by the young researchers and epidemiologists that WHO has helped to train. These publications are a key indicator that we are not just doing field work, we are doing science.
This issue regarding publication is serious. I have pushed all the researchers I have worked with to write because everything we do in the field is of high scientific importance. I was in Marseille a month or so ago at a conference on tropical medicine, the general theme was on surveillance, warning and response to epidemics. I arrived late and was listening from the back of the room to an European expert. He started by presenting data on the surveillance system in Congo at the beginning of the Ebola epidemic and all he was presenting and quoting was the work of my teams. Everything! I think we can do a lot at this level. I have this project with colleagues to write a textbook on epidemiology based on the African experience because it is obvious that we need to renew teaching in universities and research centres.

Ba and Mbaye: You are aware of the limited resources that are allocated to research in general on the continent and our dependence on international programmes. What advocacy can the WHO do to get governments to commit to making health a real research priority?

Fall: The WHO does a lot of advocacy and proposes a lot of tools for countries, but the country's political commitment must be concrete and this must be materialised by substantial investments in the field of health and health research in general. Look at our countries, they don't need an organisation that advises them to buy weapons or to protect themselves. They do it spontaneously, security is a priority for them. Why is health security, the health of the population not a priority? If countries make it a priority, resources will be invested in this sector and everyone has seen that the economic impact of pandemics and epidemics is colossal and it sets a country back over several years. We need to think about introducing health security into development policies, investing in preparedness and responses to epidemics and pandemics as a factor of economic stability. Health can no longer be the business of the Ministry of Health, it must be multi-sectoral as we say, " Health in all policies " and health in all segments of society. This is what we need in our countries today.
Ba and Mbaye: Hasn't WHO failed to mobilise, involve and make political actors aware of the importance of health security?

Fall: Drawing on the lessons of the Covid-19 pandemic, we have developed a new strategic framework: the global architecture for health emergency preparedness and response. When we talk about the global architecture, we say, there is no global without local. You can't have a global architecture if there is no strong local national organisation because in reality it happens at the country level. We work with countries to build strong national systems even when there is no epidemic, so that we have tools and procedures that can be activated when an epidemic occurs. This is done in advance. You don't wait for an epidemic to happen to decide who is going to coordinate the response, for example. This has to be known in advance and you must have teams that work and train together, that conduct simulations together, and so on. So, as we see in the army, we are not going to wait for a war to break out to decide who is doing what? The procedures and coordination of operations are clear. This is what is still lacking in the health sector. Leadership must also be national first. It is important that all partners, including the WHO, come to support the nationals. And when there is an alert, it is the country that first investigates and tries to respond at the first level, so it is important to have frontline workers capable of detecting, warning, investigating, and initiating the response. We need these capacities in all countries first. Now, when there is a need for international support, that's where organisations can help, but it shouldn't be the other way around.

There is unfortunately a lot of political instability in African countries, governments come and go, we restart all the time. If you go back to the Alma Ata Declaration on Primary Health Care of 1978, community involvement, socio-anthropological aspects, everything was already in that document, but in reality, it would be important to review what has been implemented. In 1996 in Senegal, I presented a thesis on community participation and the multi-sectoral approach in the fight against malaria in Podor. There are things that have been done, but how can these approaches be systematised? The WHO can produce all the documents possible, but we need to have the necessary leadership at the country level to undertake actions, to engage in concrete strategies that allow us to introduce the health component into all policies. At the political level, African countries need to be more active

in the discussions that take place at the global level, for example at the World Health Assembly or during certain consultations, so that Africa's voice could be heard.

Ba and Mbaye: At the outbreak of Covid-19, we all heard the negative projections about the fate of the continent. How did you, as an African, feel about this within the WHO?

Fall: I just spoke about this in the press conference because there was a question about Ebola projections in Uganda and I took the opportunity to recall the projections that were made for Africa with Covid. Epidemiology is a complex science. It is not just a mathematical model, otherwise all mathematicians would be epidemiologists. Of course, there is biostatistics in epidemiology, but the social sciences, socio-anthropology, are crucial! one can't put that into models; one can't anticipate the behaviour of populations; almost every village is unique; every epidemic is unique. In an epidemic, one can have several epidemics. It's the ability to combine biomedical science, socio-anthropology and field interventions to make decisions. It's all this that makes up field epidemiology. So you can't sit in an office and make predictions. Of course, you can make predictions for planning purposes, to see what the best possible scenario is and what the worst possible scenario is, but one cannot go and tell people "You're going to have thousands, millions of death cases". The proof of this? Even afterwards, when we assessed the excess mortality from the pandemic, it was the other continents that were more affected than Africa because there are a lot of other factors that come into play, there's the age of the population, there's previous exposure to coronavirus infections and a whole bunch of other factors.

Ba and Mbaye: Did these predictions that did not come true change anything about the discourse on Africa? Do they take more precautions?

Fall: It's not going to change anything because they are the same people who are in universities and think tanks in the West writing nice articles and who have never helped stop a single epidemic. They're going to keep writing. There are too many armchair epidemiologists who sit in an office somewhere and make projections, and everybody has become an expert in Global Health. That's the problem. Have they actually been involved in an epidemic? They never did. If you've never done it, you can't be an expert on it and tell people what to do.

Ba and Mbaye: Covid-19 has also revealed our vaccine dependency. What about the pharmaceutical challenge?

Fall: It's an important challenge for the production of vaccines or medicines, and Africa must position itself. I see that things are starting to move in certain countries such as Senegal with the Pasteur Institute and in Rwanda, South Africa and other countries. The continent must position itself in the production of vaccines for the diseases that predominate in Africa, but also for other risks at the global level, such as pandemics. There is no reason today why African countries cannot produce medicines. But of course, it is important that we have a system of regulation and quality control and everything that goes with it. In this area, Africa has a say and an important role to play in the future.