The Role of Universities in Driving Health and Social Equity During COVID-19 and Beyond

During COVID-19, we have learned that ensuring equity in health service delivery and in societies at large while responding to health threats requires a steadfast commitment to promoting equity. Universities, as institutions tasked with research for knowledge creation and the training of the next generation of global health leaders, could play a critical role in helping address health inequities during health threats and beyond. This requires universities to revolutionize the way they function internally at all levels, from admissions, hiring policies, curricula development and delivery, to financing structures. The University of Global Health Equity, a health sciences university based in Rwanda, makes this approach a pillar of its education delivery and serves as an example for universities aiming to drive progress towards equity in global health and in society at large.

Tackling inequity within universities

Responses to COVID-19 are more effective when inclusive. Inclusivity is a culture that universities need to practice, cultivate and transmit as an important value to their students. Two areas that illustrate these points are economic and gender inclusion. UGHE ensures that all, regardless of individual characteristics or capacity to pay, can enroll. However, this is not the norm everywhere – but it ought to be.

Firstly, 95% of master's programs in global health are based in HICs and are often unaffordable to those in low and middle-income countries (LMICs) where the burden of disease is the

highest and the number of health professionals the lowest. This coupled with brain drain from LMICs to HICs contributes to the estimated shortage of 6million health workers that Africa will face by 2030 and the loss of billions of dollars invested by poor countries in health education. With the understanding that many African students cannot afford such quality education, all our master's students benefit from scholarships that take into account their ability to contribute. Our medical students are educated for free as we have created an innovative agreement called Umusanzu (the Kinyarwanda word for contribution) signed between UGHE, the Ministry of Health and the students. In exchange for this free education, they commit to work for 6-9 years within the public sector.

Secondly, female academicians are less likely to hold senior positions and are subject to a gender wage gap of around 11%.Female medical students report gender discrimination and sexual harassment that impact their performance and career advancement. Moreover, cultural factors and domestic care responsibilities prevent women from engaging actively in long-term research studies and from seeking higher-level positions in academia. These factors contribute to the fact that only 28% of physicians in Africa are female and only 25% of global health leadership positions worldwide are held by women. However, as research has proven that more equitable health systems and better clinical outcomes result from increased female representation, this gender inequity within academic institutions can negatively impact health service delivery. During health threats such as COVID-19, these inequities in higher education and more broadly are exacerbated. Noting that pandemics can have significant repercussions for population health as ordinary health services are interrupted, efforts to improve health systems by addressing all forms of inequity become even more important.

To respond to these challenges, UGHE has adopted a gender

equity approach, not an equality approach as this would not fully address the current gender gap. UGHE has a bold requirement that 70% of students in its medical program and 50% in all master's programs must be female. The Center for Gender Equity mainstreams gender considerations into the university's curricula, policies, strategies, and practice and monitors this progress through a regular gender and diversity audit.

Embedding universities within communities

An important criticism of universities is that they are detached from the on-the-ground realities of vulnerable populations. This prevents universities and their students from fully understanding the social determinants that could result in inequities in health risks, outcomes, and services.

This is why UGHE is based in the remote, rural district of Butaro in the North of Rwanda. Students have the entire health sector as their classroom and learn from health practitioners and decision makers at national, district and community levels. With their teachers and the administrative and finance teams, students practice direct community engagement to support socio-economic improvement. This community-based medical education is accompanied by a strong humanities curriculum that enables students to look beyond the clinical contributors to illness, evaluate health system challenges through a historical, anthropological and sociological perspective and ultimately challenge the existing global structure of power that continues to exploit the vulnerable.

Training in leadership and management

We know that refusing to apply scientific knowledge puts populations and health professionals at risk. However, applying science is not sufficient. Universities should enable future scientists – health professionals, economists, sociologists, and political science experts – to take lessons

from past outbreaks by explaining the "what", the "why", and the "how" of response to health threats, with approaches adapted in ways that ensure cultural acceptance and trust building. They should train all clinicians in social, community-based medicine, equip them with the skills to examine healthcare holistically through a biosocial angle, as well as with the managerial and leadership skills needed to build, repair and manage equitable and resilient health systems. At UGHE, this is a core component of all curricula and training and our Executive Education program transfers such skills and knowledge to health practitioners already in service in Rwanda, elsewhere in Africa, and beyond.

Addressing health inequities through research

During COVID-19, researchers were under pressure to understand the virus and to find rapid interventions such as vaccines to halt the spread of the virus. The partnership between Oxford University and AstraZeneca which led to the development of one of the most widely used COVID-19 vaccines demonstrates this point. Oxford University applied an equity approach in research by conducting clinical trials of the vaccine in collaboration with the University of Witwatersrand in South Africa to ensure its efficacy in Africa. They also decentralized vaccine production out of high-income countries (HICs) through an agreement with the Serum Institute of India.

However, few universities focused on addressing socio-economic and health disparities exacerbated by COVID-19. In fact, studies have shown that minority groups are inadequately represented in research, with just a few out of the 1,500 COVID-19 studies registered at the National Institute of Health clinical trials reporting data segregated by ethnicity. Inclusion of minority groups in studies is important to ensuring that health tools are equally efficient for all. Using this pandemic as an example, UGHE teaches that minorities and marginalized citizens are more vulnerable and conducts research to understand and address these inequities.

As we move towards evaluating universities based on their contribution to the Sustainable Development Goals (SDGs), UGHE stands as a prime example of how universities can address inequities.

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