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Closing the diversity and inclusion gaps in francophone public health: a wake-up call

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INTRODUCTION

Is the COVID-19 pandemic ultimately just another episode in the history of our era marked by lack of diversity (in gender, discipline, sector, method, origin and age)? Several analyses have already revealed the exclusion of women, civil society or interdisciplinarity in the fight against the COVID-19 pandemic.[1 2] In the world of French-speaking public health, this lack of diversity is not only flagrant but above all historical and structural. The absence of diversity is widely known but never considered as a problem to be solved. It is an open secret, which like others in public health,[3] manifests in the fight against the COVID-19 pandemic.[4]

Our point of view in this editorial is part of a vision of public health in the broadest sense of the term, open to the world and to interdisciplinarity, not limited to epidemiology, biostatistics or even health education and behavioural change. We are part of a holistic public health,[5] which is in line with very old proposals for a new public health.[6] We want to draw attention to the persisting lack of diversity in francophone public health and to stimulate a collective debate to find solutions. Without diversity, which implies a fundamental renewal of ways of thinking, people, approaches and paradigms,[7] our indignation will still be valid when the next pandemic arrives. Taking diversity seriously means recognising the plurality of our contemporary societies so that our public health actions are more adapted and therefore more equitable, effective, and fair.

ALARMING FINDINGS ON THE LACK OF DIVERSITY

Let us begin by painting a picture of this lack of diversity. We focus on three types of flagship public health institutions: (1) public health authorities and COVID-19 scientific committees (2) public health education and research and (3) public health advocacy groups and societies. To show that our observation persists and transcend beyond borders, we illustrate our point with three French-speaking nations/provinces (France, Quebec and Burkina Faso) from three continents (Europe, North America and Africa) where the three of us have lived and worked.

Public health authorities and COVID-19 scientific committees

The most recent opportunity to take diversity into account is the current fight against the COVID-19 pandemic. However, this has not been the case. In France, the scientific committee, chaired by a person over 70 years old, was created on 12 March 2020 and was originally composed of 11 people, of which only two were women, most were biomedical experts and there were no public health experts. The committee had only two social science experts, whose relevance was questioned.[8] On 24 March 2020, another committee was set up (Research and Expertise Analysis Committee) chaired by a person over 70 years of age. Biomedical experts dominated on this committee. Neither of the two committees had Black members and neither originally had any civil society or patient representatives. In January 2021, France announced the creation of a new research agency for infectious and emerging diseases. The Minister of Higher Education and Research says she wants to 'favour a multidisciplinary approach'. But the composition of the group put together to discuss the place of human and social sciences in this new agency indicates little confidence in the younger generation to lead the discussions. We hope this intended multidisciplinary approach goes beyond research associating virology with molecular biology.

In Quebec, to the best of our knowledge, no COVID-19 scientific committee has been set

up. The province announced the creation of an advisory committee for clinical research. However, the composition of the committee has not been made public, which may call into question the transparency of the committee formation. Foreign-trained doctors find it very difficult to practice their profession and this limits the diversity of professionals (unlike support staff). Besides, it was the panic of the epidemic in May 2020 that led to the decision of hiring foreign-trained doctors for prevention activities. If we look at public health institutions, we see that of the 15 members of the Board of Directors of the Institut national de santé publique du Québec (INSPQ), there is only one visible minority. The same observation applies to the institute's organisational chart, which is particularly noteworthy for its homogeneity. The Institut national d'excellence en santé et en services sociaux (INESSS), a key reference for informing decisions and practices, is doing no better. Of the 11 government-appointed board members, the absence of racial minorities is striking.

In Burkina Faso, we were unable to obtain the exact composition of the scientific and technical committee set up to combat COVID-19. The withholding of information on the composition of this committee may suggest the willingness to guard against criticism. The national committee for the management of the COVID-19 pandemic is composed mainly of ministers and representatives of institutions, but not of experts who are recognised for their competencies in the management of such crises. Of the 19 members, only five are women.

Public health education and research

In France, majority of public health training courses are focused on epidemiology, with very few university courses on prevention or health promotion. The École des hautes études en santé publique (EHESP School of Public Health), initially responsible for training hospital directors, has just published a reference manual on public health; its table of contents shows this long-held view. EHESP has, however, published a book on health promotion,[9] the diversity of which is the opposite of that of their reference manual on public health—written by five men and one woman with two prefaces written by two men, both physicians.[10] In April 2020, one of the preface writers, the director of the school and a public health physician, proposed to 'fundamentally rethink the concept of public health', referring to the old Pasteurian triptych of the virus, the host and the environment[11]—far from a new public health![6] Until 2021, France remained one of the few countries in the world where, before applying for a teaching post in a university, one had to be qualified by a national commission, which, for the field of public health is essentially composed of people with biomedical and epidemiological training. Almost all university teachers of public health are physicians, mainly men, hospital practitioner, trained in epidemiology.

In Quebec, public health education has traditionally been divided in a confrontation between Montreal and Quebec City, the capital of the province. In the metropolis, McGill focuses on biomedical and epidemiological public health (only in English), while the University of Montreal (UdeM) offers a more open public health education with specialties in health promotion, healthcare organisation and evaluation for example. However, in its desire to be accredited by the *Council on Education for Public Health (CEPH)*, the UdeM has, over time, lost its diversity by refocusing on traditional public health, leaving little room for participatory approaches and community health.[12] On the other hand, in Quebec City, teaching focused on community health has always prevailed, with a multifaculty doctorate that is not without enormous challenges of disciplinary power struggles[13] and struggles to recruit students. Moreover, although the UdeM School of Public Health has just appointed a Black dean of Haitian origin for the first time in its history, teachers representing this cultural diversity are very rare. The vast majority of students come from abroad, particularly from French-speaking African countries, which is not at all the case for the teaching staff. Even in the field of global health,[14] where one would expect a higher degree of diversity, teacher recruitment has only benefited North Americans or Europeans. It is universities in remote regions of Quebec province in Canada, which are considered subordinate, that recruit students who have obtained their degrees in public health at the UdeM as professors.

In Canada, the government's recent decision to encourage educational and research institutions to ensure equity and diversity through the Canada Research Chairs Program reflects the lack of progress in the representation of women, persons with disabilities, Aboriginal peoples and visible minorities. For example, of the nine francophone research chairs awarded in 'population health' in Quebec, it was not until June 2020 that a visible minority person was awarded a Chair. And while the Fonds de recherche du Québec - Santé (FRQS), for its part, has succeeded in achieving a balance on its board of directors 'between the different scientific fields, institutions, regions and gender representation', the organisation needs to do more to keep up with changes in Quebec society. In May 2018, the Canadian Institutes of Health Research (CIHR) launched a new procedure aimed at providing more equitable access to health research funding for participants. However, this remained only an announcement, with researchers only filling out questionnaires.[15]

In Burkina Faso, where diversity mainly concerns gender and disciplinary issues (even if the question of regional representations is a major political issue, including in the health system[16]), we also note a virtual absence of women among the teaching staff, both in public and private health training institutes. There is only one woman among the nine members of the national public health institution's Board of Directors and women represent only 28% of the administrative, technical and scientific staffs of the institution. With the National Fund

for Research and Innovation for Development, which is the main funding institution, the observation is the same. The scientific and technical committee set up within the framework of COVID-19 call for projects, made up of some 20 resource persons in the fields of research, innovation and/or development, seemed to include only two women. It was only in 2018 that the second woman Minister of Health was appointed in Burkina Faso, replaced at the beginning of 2021 by a man. And yet, the Heads of State of the African Union committed in July 2004 to increase women's participation in all decision-making bodies and elected positions to at least 30%.[17]

Public health advocacy groups and scholarly societies

The French public health society has taken gender diversity into account but for other diversity concerns. Its president is a hospital physician. There are three women assistant editors of its scientific journal but the chief editor, a retired gerontologist, is a man. The journal has a section dedicated to articles on 'Africa, public health and development' but it is not headed by a person from the continent, even though the editorial board includes several African experts. In Paris, in 2016, think tank was created for Global Health 2030. While gender and disciplinary diversity is respected, age diversity is less so. Above all, no racialised person seem to have been invited to this 'think tank'. The composition of the global health group is in line with French public health.

In Quebec, while many recognise the importance of mobilising a diversity of ideas, skills and experience in order to build a more inclusive and dynamic society,[18] much remains to be done in public health. Francophone public health advocacy groups and learnt societies are marked by a persistent lack of diversity. The Association pour la santé publique du Québec has no visible minority among its employees, although it does have a retired racialised physician on its board of directors. Not surprisingly, the Quebec College of Physicians also does poorly on diversity issues. Of the 16 members of its Board of Directors, there is only one visible minority, a non-physician. As for the Canadian Journal of Public Health, it has few visible minorities on its editorial board which consist of 10 francophone members. However, at the end of 2020, it has just announced an editorial policy aimed at not participating in the stigmatisation of Aboriginal peoples.[19]

In Burkina Faso, the ethics committee of the national public health institute have more than 41% female members from diverse disciplines. But we could not find data on the composition of the groups such as the National Public Health Association or the CNRST's public health journal.

POSSIBLE EXPLANATIONS AND SOME CONSEQUENCES

The concept of path dependency explains the persistence of epidemiological and biomedical public health in the French-speaking world. It is as if since Pasteur, the world of public health had become frozen[7] and that primary healthcare, the Ottawa Charter or the WHO Commission on Health Determinants never existed.[20] The global definition given by the WHO as early as 1946, highlighting the trilogy of biological, mental and social health, does not seem to have succeeded in influencing this dominant vision of health strongly distorted by a biomedical paradigm,[21] with consequences for the content of interventions, their funding and the nature of academic teaching.[22 23] The influence of epidemiology in the field of public health persists. But history teaches us that no medicine can fundamentally treat disease without taking into account their sociogenesis.[24] The importance of health seems to be proportional to messages of insecurity and collective fear transmitted by the media and experts. The infantilisation of populations in the fight against the COVID-19 pandemic is a regrettable example of this approach,[25] sad but recurrent.[26]

Another explanation is the emergence of bio-power as early as the 19th century,[27] which leaves public health unconstrained by forces that can persuade it to change its paradigm.[7] Despite some progress, francophone public health seems to have missed the opportunity for diversity. In fact, its many professions of faith now seem like a refrain whose voice no longer carries an echo. Beyond an ethical issue,[15] diversity remains fundamentally a determining parameter of originality and creativity[18] whether in teaching or in the choice of public health actions. In an interview, Lila Bouadma, member of the COVID-19 scientific committee in France and reanimator at the Bichat hospital in Paris, describes the almost insurmountable challenges for a woman, born in France of parents who came from Algeria in the 1960s, to make a career[28] in a discipline where the weight of pedantry and patriarchy are intense.[29] These challenges seem to be permanent and borderless.[30] From the USA to Burkina Faso, work has long shown that public health is not free from racism[31] or ethno-cultural biases.[16]

COLLECTIVE SOLUTIONS?

How can the younger generations be assured of a place in the public health community when they see their elders continuing to accept positions of responsibility long after their official retirement? How can women and racialised people still believe they have a place in a field where they are so rarely represented? How can public health students have a vision of this field in all its complexity when most of the teaching and teaching staff are in the field of epidemiology, and biostatistics? All these will only be possible in the first place if the challenges of diversity are made visible, as we have tried to do in this article with a few examples, which we hope may help trigger reflections and discussions on potential solution, for example, by individuals who hold power. The reflexive stance required of public health actors[32] should enable us to ask ourselves whether, in our daily professional activities,

we are doing everything possible to promote diversity. For example, how can we, as public health researchers, give more space to young people, women and racialised people in our research projects and publications?[33 34] How can we cede some of our power, give the young ones confidence and support them to act for more effective and fair public health? Of course, these solutions also require systemic and structural changes.

As is often the case, the solution cannot be decreed. We ourselves have no drastic answer to this need for change in our societies and institutions. Change will have to come through discussion, debates and exchanges, taking into account the power stakes at the heart of the solutions to be proposed.[35] In France, the authorities have announced a major national debate to reform public health, but it is not very transparent and open processes. Will the COVID-19 pandemic be another missed opportunity to move towards a new interdisciplinary and intersectoral public health?[6] Francophone public health today seems to be evolving in a 'hyper-complex system in which multiple regimes of inequalities intersect'[36] and this state of affairs requires reflection, among others, on the question of quotas, to speed up the much-desired transition. The mere mention of this word makes one gnash one's teeth because quotas would, according to its critics, only engender a form of arbitrariness that shifts the balance between groups in favour of individual merits. But, one should not prevent oneself from imposing them, all the more so as reality resists change. Unfortunately, we can no longer rely solely on the good faith of the various parties to achieve the agenda of diversity in gender, discipline, sector, method, origin, and age.

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REFERENCES

1 Rajan D, Koch K, Rohrer K, *et al*. Governance of the Covid-19 response: a call for more inclusive and transparent decision-making. *BMJ Glob Health* 2020;5:e002655.
2 Mol A, Hardon A. What COVID-19 may teach us about interdisciplinarity. *BMJ Glob Health* 2020;5:e004375.
3 Geissler PW. Public secrets in public health: knowing not to know while making scientific knowledge. *Am Ethnol* 2013;40:13–34.
4 Pawson R, Manzano A, Wong G. *The coronavirus response: known knowns, known unknowns, unknown unknowns*. London, 2020.
5 Loewenson R, Accoe K, Bajpai N, *et al*. Reclaiming comprehensive public health. *BMJ Glob Health* 2020;5:e003886.
6 Baum F. *The new public health*. 4 edn. South Melbourne, Vic: Oxford University Press, 2015.
7 Paul E, Brown GW, Ridde V. COVID-19: time for paradigm shift in the nexus between local, National and global health. *BMJ Glob Health* 2020;5:e002622.
8 Bourgois R, Moulin A-M. *Au regard de l'histoire, le déconfinement n'a pas de modèle*. AOC media - Analyse Opinion Critique, 2020.
9 Breton E, Jabot F, Pommier J. *La promotion de la santé: comprendre pour agir dans Le monde francophone*, 2017.
10 Raimondeau J, Bréchat P-H, Carmona E. *Manuel de santé publique: connaissances.enjeux et défis*, 2020.
11 Chambaud L. Repenser fondamentalement Le concept de santé publique. The conversation, 2020. Available: https://theconversation.com/repenser-fondamentalement-le-concept-de-sante-publique-136311
12 Ridde V, Druetz T. La disparition de la communauté en santé publique et santé mondiale : origine sémantique, pragmatique ou contextuelle. In: Desgroseilliers V, Vonarx N, Guichard A, eds. *La santé communautaire en 4 actes: repères, acteurs, démarches et défis*, 2016: 311–5.
13 Desgroseilliers V, Vonarx N, Guichard A. La santé communautaire en 4 actes: repáeres, acteurs, démarches et défis, 2017. Available: http://www.deslibris.ca/ID/452987 [Accessed 22 Sep 2017].
14 Ridde V, Mohindra KS, LaBossière F. Driving the global public health research agenda forward by promoting the participation of students and new researchers: perspectives from Quebec. *Can J Public Health* 2008;99:460–5.
15 Guichard A, Ridde V. Equity at all cost-and any price-for research funding in Canada? *Can J Public Health* 2019;110:114–7.
16 Belaid L, Cloos P, Ridde V. Mobiliser des représentations ethnoculturelles pour expliquer les disparités d'accès aux soins de santé au Burkina Faso. *Can J Public Health* 2017;108:e56–61.
17 Ministère de la Promotion de la Femme. *Document de la politique nationale genre du Burkina Faso*. Ouagadogou: Ministère de la Promotion de la Femme, 2009.
18 Nielsen MW, Bloch CW, Schiebinger L. Making gender diversity work for scientific discovery and innovation. *Nat Hum Behav* 2018;2:726–34.
19 Smylie J, Marsden N, Star L, *et al*. Requirement for meaningful engagement of first nations, Inuit, Métis, and Indigenous peoples in publications about them. *Can J Public Health* 2020;111:826–30.
20 Ridde V, Guichard A, Houéto D. *Social Inequalities in Health from Ottawa to Vancouver: Action for Fair Equality of Opportunity. Promotion & Education*. . Supplément Hors Série, 2007: Vol 2. 12–16.
21 Ridde V. *Une analyse comparative entre le Canada, le Québec et la France : l'importance des rapports sociaux et politiques eu égard aux déterminants et aux inégalités de la santé*. Recherches Sociographiques, 2004: 343–64. https://www.erudit.org/fr/revues/rs/2004-v45-n2-rs835/009653ar/
22 Navarro V, Shi L. The political context of social inequalities and health. *Soc Sci Med* 2001;52:481–91.
23 Marmot MG. *The health gap: the challenge of an unequal world*. London Oxford New York New Delhi Sydney: Bloomsbury, 2015.
24 Aïach P, Delanoë D. *L'Ère de la médicalisation: ecce homo sanitas*. Paris: Economica, 1998.
25 Cambon L, Alla F, Ridde V. Santé publique : pour l'empowerment plutôt que l'infantilisation. AOC media - Analyse Opinion Critique, 2020. Available: https://aoc.media/opinion/2020/07/07/sante-publique-pour-lempowerment-plutot-que-linfantilisation/
26 O'Neill M, Pederson A, Rootman I. *Health promotion in Canada: critical perspectives*. 2nd edn. Toronto: Canadian Scholars Press Inc, 2007.
27 Fassin D. *Faire de la santé publique*. Rennes: Editions de l'ENSP, 2005.
28 de Royer S. Lila Bouadma, réanimatrice l'hôpital Bichat : « Depuis l'enfance, je sais où je vais ». Le Monde, 2020. Available: https://www.lemonde.fr/planete/article/2020/12/13/lila-bouadma-reanimatrice-a-l-hopital-bichat-depuis-l-enfance-je-sais-ou-je-vais_6063198_3244.html

29 Ouédraogo S, Gautier L, Mac-Seing M, *et al*. De-patriarchalising and levelling science for French-speaking women. *Lancet* 2019;393:e23–4.
30 Ndumbe-Eyoh S. What would it take for health promotion to take structural racism seriously? *Glob Health Promot* 2020;27:3–5.
31 Cloos P. La racialisation de la santé publique aux États-Unis : entre pouvoir sur la vie et droit de laisser mourir. *Glob Health Promot* 2012;19:68–75.
32 Alexander SA, Jones CM, Tremblay M-C, *et al*. Reflexivity in health promotion: a typology for training. *Health Promot Pract* 2020;21:499–509.
33 Kwamie A, Jalaghonia N. Supporting early-career mentorship for women in health policy and systems research: a vital input to building the field. *Health Policy Plan* 2020;35:i4–6.
34 Walker SH, Ouellette V, Ridde V. How can PHD research contribute to the global health research agenda? *Can J Public Health* 2006;97:145–8.
35 Harris P, Baum F, Friel S, *et al*. A glossary of theories for understanding power and policy for health equity. *J Epidemiol Community Health* 2020:jech-2019-213692.
36 Dubet F. Régimes d'inégalité et injustices sociales. SociologieS [En ligne], Débats, Penser les inégalités, 2011. Available: http://journals.openedition.org/sociologies/3643