Manifestations of epistemic coloniality: digital health platforms in the global south

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Platforms constitute a set of resources (services and/or content/knowledge), that facilitate interactions between parties (Bonina et al. 2021).

Platforms reproduce injustice and inequalities; they foster fear and hate online (Chan et al., 2016).

They help to integrate (politically, economically, socially) marginalised communities (AbuJarour & Krasnova, 2017; Agarwal & Sen, 2021; Díaz Andrade & Doolin, 2016) & produce social value (cognitive, professional, and epistemic) (Chamakiotis et al., 2021).

Their knowledge transfer potential addresses power inequality between Global North and Global South (Chipidza & Leidner 2019).

But what is the relevance & significance of the knowledge that gets transferred to local communities, specifically those situated in the Global South?
Digital coloniality

• Technological dependence on digitally advanced countries (Coleman, 2018; Kwet, 2019) or on imperialist platforms (Facebook, Google, Amazon & Alibaba).

• Data colonialism whereby data are extracted and appropriated to serve imperial power.

• Epistemic coloniality refers to knowledge transfer situations whereby Western knowledge becomes legitimized to the detriment of local cultures that get suppressed and othered (Taskeen, 2019; Ibarra-Colado, 2006; Jammulamadaka et al., 2021).

Research Question:
How do platforms produce epistemic colonialism?
Empirical context

MedicineAfrica in Somaliland

- We studied MedicineAfrica — a non-for-profit digital (health) platform (2008-today) which aims to bridge the education gap and provide opportunities for capacity building in fragile, poorly resourced post-conflict states, such as Palestine and Somaliland. In our study, we focus on MedicineAfrica’s activity in Somaliland.

- Somaliland is an independent, post-conflict state in East Africa with fragile education and healthcare (Woodward et al., 2014).

- MedicineAfrica brings together UK-based clinical tutors and medical doctors and students based in post-conflict states.
Empirical context

MedicineAfrica in Somaliland

• It offers organized courses that form part of local degrees at Universities in Somaliland and Continuing Professional Development (CPD) courses (such as on prevention and treatment of Covid-19).

• Content was initially delivered through recorded lectures and text-based class discussions because of poor bandwidth and subsequent dropouts.

• A later upgrade in 2014 allowed faster real-time chat, while content became archived and downloadable.

• In 2018, the platform introduced synchronous audio and video-based communications.
Methodological approach

Research strategy
• We followed a longitudinal (2016-2021) single case study approach (Cavaye, 1996) in order to gain an in-depth understanding of the platform over time.

Adopted methods
• Our data collection methods included online semi-structured interviews as a main method and complementary methods as follows:
  • Phase 1 (2016-2018): 17 interviews with 20 MedicineAfrica participants (mainly tutors, but also administrators and tutees)
  • Phase 2 (2018-2020): 30 interviews with tutees (24 medical students, 3 nurse students, 3 qualified clinicians)
  • Phase 3 (2020-2021): 30 interviews (27 qualified clinicians; 2 local administrators and platform director)

Our collected data have been analyzed on NVivo following a thematic analysis approach.
• In this study, we focus on the data we collected in Phases 2 and 3
Findings: Healthcare in Somaliland

• Healthcare context in Somaliland:
  
  • **Health infrastructure**: lack of medical specializations; diagnostic technologies & clinical protocols.
  
  • **Healthcare work**: lack of basic (for the West) clinical skills & practices (e.g., taking medical history); scarce/absence of CPD opportunities.
  
  • **Public health**:
    - Treatment of illness at home.
    - Sharp division between rural & urban areas.
    - A religious approach to health.

“They would say stuff like ‘This isn't the illness for Muslims, this happens to unbelievers’. ‘They are killing unbelievers.’ ‘It cannot reach us (Muslims).’” (Phase 3, interview 11)
Findings: Knowledge transfer & learning

• Learning achieved through the platform:
  
  • **Communication skills**: communicate diagnoses to patients and clinical reasoning
  
  • **Medical specialised knowledge** (primary & secondary care): taking medical history; trauma; radiology and obstetrics
  
  • **Up-skilling**: how to triage patients with Covid-19; how to prepare hospital facilities to accept Covid-19 patients; how to use and handle PPE equipment; how to handle complications (e.g. oxygen therapy).

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“It will change a lot of things. I am now someone who has more information on Covid-19 and is able to protect myself and protect the rights of the patient. I know how to deal with those who had serious complications; whether they need intubation and oxygen therapy. I am better equipped to handle the patients and able to give emotional support to help them recover” (Phase 3, interview 17).

“So, the teachers there in the UK, they were telling us a very good way of reaching the patients in a primary setting, that can be applied here. We are thinking of applying that here as well” (Phase 3, interview 13).
Findings: What type of knowledge can be transferred?

• Transfer of knowledge that has limited applicability due to infrastructural limitations & lack of medical equipment. This makes differences between Global North and Global South visible.

“Although, I did not have any problems with the English native speakers but when it is in Somali you feel you can ask more questions. If you ask a white person a question the understanding isn’t there. But when Somali’s are facilitating the course, you can relate to them in a social context” (Phase 3, interview 5).

• Despite its bilingual format (in part), language was still an obstacle. English language was seen outside of the social context participants shared. This lack of a common ground deterred communications; language and race became interwoven.

• Transfer of skills and knowledge that does not respond to Somaliland’s situation and problems.

‘…if a UK guy comes and says we’ve done this for 100 years and this system works, I think my people, would say you are white, we’re black, I don’t think this is going to work…’ (Phase 2, Interview 12)
Discussion/Concluding remarks: Digital epistemic colonialism

We observed a ‘phenomenon’ of digital epistemic colonialism conditioned upon:

- (a) **material infrastructures** (such as medical equipment) that did not exist in the recipient country; (b) **language** that is not participants’ mother language; and (c) **content** that misses out on the problems, challenges or idiosyncratic characteristics of the *local context*.

What is the specific role of the platform?

- **Visibility**: it made visible through its content and enabled modes of communication the dividing differences between UK and Somaliland. Although the platform aimed to bridge epistemic differences it failed to bring the two countries into proximity.

- The **inevitability (?)** of epistemic colonialism & the **value (?)** of it.

- Platforms as a way of achieving sustainability and scaling up through local ownership and growth.
References


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