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Editorial

Medical Students and Equitable Global Health Research: From Participation to Shared Power

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Introduction

Research conducted in a community does not, by itself, give that community a voice in what is studied or how the findings are used. Controversies over the control of human biospecimens1 and the conduct of clinical trials in low-income settings2 illustrate persistent questions about consent, ownership, and benefit sharing. Resources for health research are also unevenly distributed, with disparities in funding and research capacity between high-income countries (HICs) and low- and middle-income countries (LMICs).[3,4] These inequalities concern authority as well as money: whose questions receive attention, whose contributions are recognized, and whose knowledge shapes interpretation and practice.[5,6]

In this editorial, decolonizing global health research means confronting the colonial histories that shaped the field and examining and redistributing control over funding, research questions, data, and decisions about what counts as legitimate knowledge. Colonial and tropical medicine shaped the development of global health; the history of malaria control provides one example of their lasting influence.7 Indigenous scholarship cautions that decolonization entails commitments to sovereignty and land restitution that cannot be reduced to institutional inclusion.8 Other scholars argue that undoing supremacy in global health requires more than decolonization.9 Our focus here is on research governance. We therefore ask one question of every proposed action: does it redistribute decision-making authority, budget control, or control over data, or does it merely widen participation? Participation without such a transfer sits on the lower rungs of Arnstein's ladder.[10]

Medical students have a place in this effort. Student-led movements have contributed to calls for decolonizing global health, although their capacity to change institutional structures remains limited.[11] Through research projects, electives, student organizations, and scholarly publishing, students encounter decisions about partnership, credit, and accountability during their training. This editorial proposes practical ways for students based in either HICs or LMICs to support locally defined priorities, negotiate transparent research partnerships, and organize collectively for institutional change. Their participation must be accompanied by commitments from faculty, universities, journals, and funders to share authority and provide the resources needed to sustain equitable practice.

Inequity in global health research

The studies summarized in ***Table 1*** describe inequities across several fields and settings. Their findings illustrate recurring problems, although their scope and generalizability differ. Institutional incentives and constraints can help sustain these patterns.

The role of medical students

Students based in HICs and LMICs can advocate for the following changes through their research, education, and collective organizing. Each action depends on a corresponding institutional commitment. ***Table 3*** links these actions to institutional responsibilities and proposed measures of progress.

Advocate for a decolonized curriculum.

Curricula offer a practical starting point for student advocacy. Students can review reading lists, teaching materials, and clinical tools for colonial bias and ask who sets the curriculum, selects speakers, and controls the resources available for teaching. A review should examine both representation and content, including skin tone in medical textbook imagery[32] and the use of race in clinical algorithms.[33] It should also ask whether descriptions of tropical or neglected diseases explain the structural conditions shaping their distribution. Students can invite researchers based in LMICs to speak and advocate for fair compensation. Student-run journal clubs can discuss locally prioritized health problems and scholarship from the regions concerned. Students in LMICs can examine their own curricula, including their reliance on textbooks, guidelines, and cases developed elsewhere, and build seminar series around local and regional scholarship. Because challenging a curriculum can put

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students at odds with the faculty who teach and assess them, such reviews are best presented collectively and supported by faculty commitments to share curricular authority and fund speaker honoraria.

Table 1. Examples of Inequity in Global Health Research and Training

Domain	Examples documented in the cited literature	References
Authorship and credit	Studies in neurosurgery, infectious diseases, and oncology report unequal representation across author roles, including limited representation of researchers based in study countries or LMICs in leadership positions.	12-14
Funding	Limited funding and institutional support can constrain research projects and career development in LMICs. Calls for reform also address how funders allocate resources and authority.	15-18
Publication costs	APCs and other publication charges can restrict publishing options for researchers with limited funds. Country-based waivers and discounts may exclude researchers with financial need in middle-income countries.	16,17/ 19-21
Epistemic injustice	Research can undervalue local knowledge and lived experience. An analysis of WHO drug-resistant tuberculosis guidelines found that experts based in high-burden and lower-income countries were underrepresented in guideline groups and related publications.	6,22-24
Classification and terminology	Income-based labels and broad country groupings can conceal differences within and between countries and reinforce hierarchies in how people and places are described.	25
Education	Studies of international electives describe supervision costs, resource pressures, and unclear clinical responsibilities for hosts. Historical analysis also identifies hierarchical portrayals of doctors migrating from India and Pakistan to the United Kingdom.	26-29
Mobility	Visa requirements, processing delays, and costs can restrict access to international conferences and training. Late invitations and uncertainty about funding can leave applicants insufficient time to secure visas.	30,31

Legend: APCs, article processing charges; LMICs, low- and middle-income countries; WHO, World Health Organization. These examples illustrate findings from specific settings and should not be interpreted as universal patterns or proof of causation.

Practice equitable partnership in student research

Students are increasingly expected to complete research projects, often in partnership with institutions in other countries. Whether these projects model equitable partnership depends largely on decisions made before data collection begins ***(Table 2).*** Student research groups should apply principles of mutual benefit, equity, accountability, humility, sustainability, and engagement with local and global stakeholders.[34] In practice, this means being explicit about who holds decision-making authority, who controls the budget, and who sets the conditions for data reuse. Students should distinguish local academic approval from community participation. A local collaborator's endorsement does not establish that patients or communities helped define a question. Teams should agree on mechanisms through which affected communities can question the project, negotiate benefits, and participate in decisions about whether it proceeds.

Table 2. A Checklist for Student Research Partnerships

• Who proposed the research question, and who will benefit from the answer?
• What mechanisms allow patients and communities, alongside local academic partners, to question the project, negotiate benefits, and participate in decisions about whether it proceeds?
• Has a local partner agreed to lead or co-lead, and is that role reflected in the protocol and budget?
• Have all collaborators agreed in writing on authorship criteria, provisional author order, and a process for reviewing contributions and resolving disagreements, using CRediT to document contributions and ICMJE criteria to determine authorship
• Who owns, stores, and controls the data, and who sets the conditions for access and reuse?
• Have the ethics approvals, exemptions, or reliance arrangements required by the relevant institutions and jurisdictions been identified and documented
• Are fair payment, acknowledgment, and authorship considered separately, with appropriate credit for local staff and collaborators?
• How will results be returned to participants, communities, and local decision-makers?
• Is there a plan for publication or presentation in the host setting as well as internationally?

Authorship expectations should be discussed early among all relevant collaborators and recorded as provisional arrangements to be revisited as contributions evolve. The Contributor Roles Taxonomy (CRediT)[35,36] documents contributions but does not determine eligibility for authorship. It can be paired with the International Committee of Medical Journal Editors (ICMJE) authorship criteria and an agreed process for reviewing contributions and resolving disagreements.[37] Contributors who meet the first ICMJE criterion should have the opportunity to participate in drafting or critical review and final approval; denying them that opportunity must not become a means of excluding them from authorship.[37] Local collaborators should have opportunities to contribute to design, analysis, interpretation, and writing, with appropriate credit, to prevent authorship parasitism and token authorship.[38,39] Fair payment, acknowledgment, and authorship recognize different contributions and should be considered separately.

Students should document the ethics approvals, exemptions, or reliance arrangements required by the relevant institutions and jurisdictions. They should also plan how findings will be returned to participants and communities and consider local journals, policy briefs, and presentations in the host setting alongside international publications. Students based in LMICs can propose projects through their own institutions, journals, research groups, and South-South networks. Because questioning supervisors or institutions can put students at risk, these conversations are best held collectively, with support from faculty allies and student organizations.

Reform electives, exchanges, conferences, and meetings

Electives and exchanges

Learning in global health should flow in both directions. Reverse innovation40 expresses this idea, although empirical work suggests that the term can reinforce the directionality it seeks to challenge.[41] A South-North patient safety partnership described

how hospitals in Liberia, Uganda, and South Sudan offered lessons to Johns Hopkins Medicine through open visiting, bedside rounds, and family involvement in patient care.[42] For electives and exchanges, priorities should be defined by the host, with visiting students' learning objectives compatible with those priorities. Hosts should decide what visiting students may do and should be compensated for supervision and other resource costs.[26,43] Knowledge exchange should be bidirectional and grounded in humility.[43,44] Students can share learning objectives before departure, work within their competence under local supervision,[45,46] and agree with hosts on a useful contribution.45 Student organizations can support reciprocal placements for students based in LMICs. Students in LMICs can also propose South-South exchanges and help set the terms on which their institutions host visitors.

Table 3. A Checklist for Student Research Partnerships

Domain	Student action	Institutional commitment	Proposed measures of progress
Curriculum	Review reading lists, images, and clinical tools. Invite scholars based in LMICs and organize journal clubs around their work.	Give LMIC-based scholars formal roles in curriculum design and review. Fund speaker honoraria and publish the findings of an annual review informed by students.	Share of assigned readings authored by LMIC-based scholars; share of sessions led by them; proportion of honoraria paid within an agreed period; student feedback on teaching and assessment.
Research partnerships	Agree on authority over questions, budgets, and data before collection. Apply ICMJE criteria and CRediT, keep author order provisional, separate payment from credit, and document ethics arrangements.	Require a partnership agreement before a project starts. Give partners and community representatives agreed decision-making roles and fund the return of results.	Share of projects with agreements signed before data collection; budget controlled by local partners; contributions and authorship reviewed; results returned; independent partner feedback on whether their input changed decisions.
Electives, exchanges, and conferences	Share learning objectives, work within competence under local supervision, and agree on a useful contribution. Advocate for visa support, accessible formats, and fee assistance.	Let hosts set priorities and compensate supervision. Offer reciprocal placements, choose accessible venues, issue invitations early, and provide assistance based on need.	Documentation of host-defined priorities; share of hosts compensated; reciprocal placements per year; participation by LMIC-based delegates and speakers; outcomes of visa and fee-assistance requests.
Language, images, and categories	Use accurate disease and virus names. Obtain publication consent in a language the person understands. Explain categories and disaggregate where justified.	Publish guidance on language, images, consent, and classification. Incorporate it into editorial and ethics review and train reviewers.	Share of submissions and protocols assessed against the guidance; justification of categories in outputs; documentation of understandable consent; publication of guidance adoption and review dates.
Institutional and funder accountability	Audit institutional practice collectively and present findings and proposals to academic leaders.	Assign a responsible senior official and fund a written response by an agreed deadline. Provide an independent complaints process and protection from retaliation. Support multiyear funding and agreed exit terms.	Repeat and publish audits at agreed intervals; track proposals adopted or answered; report aggregate complaint outcomes while protecting confidentiality; disclose the share and duration of funding controlled by local partners.
Positionality and diaspora	Reflect on knowledge, relationships, assumptions, privileges, and accountability. Include varied perspectives and use diaspora networks to support local partners.	Recognize and fund diaspora contributions while preserving local partners' authority over priorities, budgets, and data.	Positionality statements explaining effects on the work; partner feedback on diaspora involvement; documentation of local partners' decision-making authority.

Legend: CRediT, Contributor Roles Taxonomy; ICMJE, International Committee of Medical Journal Editors; LMICs, low- and middle-income countries. These are proposed process measures, not validated measures of equity. Partners should agree on targets, reporting responsibilities, and timelines locally and interpret counts alongside qualitative feedback.

Conferences and meetings

Student and professional organizations should consider LMIC venues and other locations where visa requirements, costs, and processing times permit broad participation.[47] For example, the International Health Economics Association moved its 2025 Congress from Calgary, Canada, to Bali, Indonesia, citing delays, costs, and uncertainty in Canadian visa processing.[48] Organizing committees should issue invitations early and provide supporting documentation and institutional assistance where appropriate. Hybrid formats offer another way to participate. The International Journal of Medical Students' World Conference of Medical Student Research provides an example of a fully online international conference run by medical students and early-career researchers.[49,50] Online formats can reduce travel and visa barriers, although language, connectivity, and time zones can still limit participation. Students in LMICs can also establish or join student-run journals, peer-review training programs, and regional meetings through South-South networks,[51] helping set agendas and publication practices closer to where research is conducted.

Costs require separate attention because manuscript submission fees, article processing charges (APCs), abstract fees, and conference registration fees create different barriers. For compliant open access journals and publishing platforms, Plan S requires APC waivers for authors from low-income economies, discounts for authors from lower-middle-income economies, and waivers or discounts for other authors with demonstrable need.[19] Country-based eligibility can nevertheless exclude researchers who lack funds in middle-income countries.[20,21] Assistance should therefore reflect financial need as well as country income classification, consistent with the concerns about broad labels

discussed here.[25] Published descriptions of Wiley's automatic APC waiver program illustrate one form of country-based support,[52] such programs should be complemented by transparent mechanisms for individual needs-based assistance.

Use language, images, and representation with care

Students should describe hosts as partners or collaborators and use language that emphasizes mutual learning. They should distinguish the virus SARS-CoV-2 from the disease COVID-19 and avoid stigmatizing geographic labels.[53] In a Rwandan study, some local learners found visiting students' repeated descriptions of their institution as poorly resourced diminishing.[43] Before publishing identifiable patient images or narratives, students should obtain explicit consent for publication in a language the person understands and follow applicable documentation requirements. Country and resource classifications should identify the specific dimension being measured rather than rely on labels that conceal variation.[25] Ancestry, ethnicity, racialization, nationality, and residence are distinct constructs. The categories used should fit the research question, be explained, and be disaggregated where justified and feasible. Broad groupings such as people of color or Black, Indigenous, and people of color (BIPOC) should not replace more specific categories without justification.[25]

Hold institutions and funders accountable

Students can advocate collectively for institutional policies that support South-South51 and South-North54 partnerships. They can audit their institutions' progress, publish the findings, and submit proposals to academic leaders. Students in LMICs can press their universities and national medical associations to fund local research groups and develop partnership policies. Such proposals should address who holds decision-making authority and budget control, alongside participation. Audits and proposals can expose students to retaliation; they are best undertaken collectively and with institutional protections.

Calls for funders to share authority must also address dependence on external financing. In May 2025, the US National Institutes of Health (NIH) announced restrictions on traditional foreign subawards, through which a prime recipient transfers funds to a partner abroad.[55] A subsequent policy introduced a linked award structure for international components, effective for relevant application due dates on or after January 25, 2026.[56] The change reorganized funding arrangements; it did not end NIH support for international research. Reporting during the 2025 funding disruptions described threats to South African tuberculosis and HIV research capacity.[57] These events underscore the vulnerability of partnerships that depend on decisions made by external funders. Separate awards should be assessed by whether they give international partners meaningful authority over resources and scientific priorities. A fuller approach to shared power would include domestic and South-South financing, multiyear core funding, and contractual protections such as notice periods and agreed exit terms.

Navigating power as an HIC-based student with ties to an LMIC Institutional location can shape access to funding, networks, and recognition. Global health practitioners have described hierarchies that privilege institutions and expertise associated with the Global North.[58] A student based in an HIC may therefore have forms of institutional access unavailable to some colleagues in a country with which that student has family or cultural ties. Shared ancestry does not erase these differences, but institutional privilege should not be assumed to be uniform. Language, migration history, relationships, and sustained involvement can vary substantially, so neither insider nor outsider status should be presumed. Positionality reflection is useful for everyone on a research team: what knowledge, relationships, assumptions, privileges, and accountability obligations does each person bring?[59] Teams should draw on varied perspectives in design, analysis, and interpretation without treating an outsider's interpretation as inherently more rigorous than local knowledge. Diaspora health workers can connect institutions and support opportunities for colleagues in countries of heritage.[60] The Tropical Health and Education Trust's 2021 report, Experts in Our Midst, recommended a network to identify, document, and support diaspora-led relationships and explicitly included student groups among potential participants.[60] Student organizations can adapt this approach while ensuring that diaspora involvement supports local partners' authority rather than substituting for it.

Limitations

Student-led initiatives have limitations. A reading list with a few authors based in LMICs, a pledge without follow-up, or a student-led committee with a restricted budget may benefit an institution's reputation while leaving its practices intact. Expecting students to correct systems sustained by faculty, funders, and institutions places an unfair burden on them. Students remain subject to grading, recommendations, and funding decisions controlled by these actors. Collective organizing through student unions, professional associations, and global networks may help students share risk and negotiate change, but it does not remove their vulnerability. Student action therefore requires institutional support, protection from retaliation, and meaningful authority. It cannot substitute for systemic reform. The measures in Table 3 are proposed process indicators, not validated evidence that equity has been achieved; they should be interpreted alongside feedback from partners and communities.

Conclusion

Decolonizing global health research is ultimately a question of power. Medical students cannot transform its structures alone, but their training can shape how future investigators, funders, editors, and policymakers share authority and resources. The actions proposed here offer practical starting points for research governed with meaningful participation by the people and institutions affected. Their value depends on faculty, universities, journals, and funders providing the resources, protections, and decision-making authority that equitable practice requires.

Accountability must extend to the communities and partners on whom global health research depends.

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