

## Commentary Article

# Decolonising Medical Education in Low- and Middle-Income Countries: Reclaiming Social Accountability Beyond Commercial Metrics

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## Introduction

Medical education in low- and middle-income countries (LMICs) is experiencing profound transformation. Expansion of private educational institutions, increasing global competition, international accreditation systems, and growing commercial influences have reshaped how medical schools define quality, excellence, and success. While these developments have contributed to educational expansion and international engagement, they have also intensified concerns regarding equity, social accountability, and the extent to which medical education remains responsive to local population health needs.

Recent evidence suggests that commercialisation and neo-colonial influences increasingly intersect within medical education systems. A qualitative evidence meta-synthesis examining studies from LMICs identified recurring patterns through which market incentives and external systems of legitimacy influence educational priorities, professional identity formation, and institutional decision-making [1]. Four interconnected mechanisms emerged: credential dependence linked to migration markets, market-driven educational recruitment, commercial influence on continuing professional development, and accreditation functioning as a market signal. Collectively, these mechanisms illustrate how commercial and neo-colonial forces can reshape institutional priorities, often privileging market value over social value.

These findings raise important questions regarding the purpose of medical education. Should educational success be defined primarily through international recognition, accreditation status, and graduate mobility, or through meaningful contributions to population health and health system strengthening? This commentary argues that the central challenge facing medical education in LMICs is not commercialisation itself, but the growing dominance of commercial and externally driven metrics over the social mission of medical education. Decolonising medical education therefore requires renewed commitment to social accountability, local relevance, and educational sovereignty.

## Commercialism and the Reproduction of Dependency

Commercialisation and neo-colonialism are often treated as distinct phenomena, yet they frequently reinforce one another. Market

forces increasingly shape educational priorities while simultaneously strengthening dependency on external standards, credentials, and systems of validation [1].

One of the most visible manifestations of this dynamic is credential dependence. Qualifications and examinations associated with high-income countries continue to function as markers of prestige, competence, and professional legitimacy. For many students, educational success is increasingly linked to opportunities for international mobility rather than service within local healthcare systems. Educational institutions may consequently adapt curricula, assessment systems, and strategic priorities to support these aspirations.

Such processes contribute to what Abimbola describes as the "foreign gaze," whereby external actors and institutions exert disproportionate influence over how value and legitimacy are assigned [2]. Within medical education, this can result in the privileging of externally derived standards and knowledge systems while local expertise, contextual realities, and community priorities receive comparatively less attention.

Commercial pressures further intensify these dynamics. Competition for students, international partnerships, and institutional prestige may encourage medical schools to align themselves with globally recognised benchmarks. Although these efforts can enhance visibility and reputation, they may also redirect attention away from pressing local health needs. Educational quality becomes increasingly associated with external recognition rather than measurable contributions to healthcare delivery and population health.

The concern is therefore not that commercial investment or global engagement are inherently problematic. Rather, difficulties arise when market-oriented values become the dominant organising principle of educational systems and displace commitments to public service and social responsibility.

## Accreditation, Regulation, and Educational Sovereignty

Accreditation has become one of the most influential forces shaping contemporary medical education. Ideally, accreditation promotes quality improvement, accountability, and transparency. However, accreditation systems do not operate in a political vacuum.

Rashid et al. argue that regulatory and accreditation processes must be examined through a decolonial lens because standards developed within particular educational, cultural, and economic contexts are frequently transferred across diverse settings with limited adaptation [3]. Consequently, accreditation may function not only as a mechanism for quality assurance but also as a vehicle through which external assumptions regarding educational excellence are reproduced.

The findings of Khan et al. [1] suggest that accreditation increasingly serves a dual purpose. While it continues to support quality improvement, it also functions as a form of market currency used for institutional branding, recruitment, and competitive positioning. Under such conditions, institutions may prioritise compliance with measurable indicators rather than meaningful educational transformation.

A decolonised approach to accreditation does not require rejecting standards or abandoning international collaboration. Rather, it requires recognising that educational quality cannot be reduced to technical compliance alone. Regulatory frameworks should support educational sovereignty by allowing institutions to respond to local health priorities while maintaining rigorous standards. Quality indicators should therefore include measures of social accountability, community engagement, workforce distribution, and responsiveness to national health needs.

### Reclaiming Social Accountability

If commercialisation and neo-colonial influences risk distancing medical education from its social purpose, social accountability offers a framework through which that purpose can be reclaimed.

Boelen and Woollard argue that socially accountable institutions direct their education, research, and service activities towards addressing the priority health concerns of the populations they serve [4]. This perspective shifts evaluation away from purely institutional achievements and towards societal impact. Questions of educational quality become linked to workforce retention, health equity, community engagement, and contributions to health system strengthening.

This approach is particularly relevant in LMICs, where healthcare systems frequently face workforce shortages, uneven service distribution, and substantial disease burdens. In such settings, educational excellence should be measured not only by institutional prestige but also by the ability of graduates to address local health challenges and improve healthcare outcomes.

Importantly, social accountability does not imply isolation from global educational networks. Rather, it encourages forms of collaboration grounded in reciprocity rather than dependency. Abimbola highlights the importance of recognising LMIC institutions as producers of knowledge rather than passive recipients of expertise [2]. Decolonising medical education therefore requires creating space for local perspectives, local scholarship, and contextually relevant innovation within global educational conversations.

Recent guidance from Abdalla et al. further emphasises that

social accountability should be embedded throughout the educational continuum rather than treated as an aspirational principle [5]. Curriculum design, assessment systems, institutional governance, and accreditation frameworks should all reflect commitments to community needs and health equity.

### Towards a More Equitable Future

The future of medical education in LMICs will inevitably remain connected to global educational systems. The challenge is not whether institutions should engage internationally, but how such engagement can occur without undermining local relevance and social responsibility.

Several priorities emerge from current evidence. First, educational institutions should critically evaluate the influence of commercial incentives on decision-making processes and ensure that financial considerations do not supersede public health priorities. Second, accreditation and regulatory systems should incorporate measures of social accountability alongside traditional quality indicators. Third, greater investment is required in locally generated research, educational leadership, and scholarship to reduce dependence on externally defined models of excellence.

Most importantly, the definition of educational success must expand beyond accreditation status, rankings, and graduate mobility. Success should also be reflected in stronger health systems, improved health outcomes, reduced inequities, and meaningful contributions to the communities medical schools are intended to serve.

It is important to recognise that LMICs are not a homogeneous group, and the manifestations of commercialisation and neo-colonial influence may vary considerably across educational, regulatory, and health system contexts.

### Conclusion

Commercialisation is not inherently detrimental to medical education. Investment, innovation, and international collaboration have contributed substantially to educational development across many LMICs. However, challenges emerge when market-oriented values become the dominant framework through which educational success is defined and evaluated.

Evidence from recent scholarship suggests that commercial and neo-colonial dynamics frequently reinforce one another, shaping educational priorities, professional aspirations, and institutional behaviour in ways that may distance medical education from its social mission [1]. Medical education exists not merely to produce internationally competitive graduates, but to strengthen health systems, advance health equity, and improve population health outcomes within the communities it serves.

Decolonising medical education therefore requires more than curricular reform. It demands a critical re-examination of the values that define educational excellence and a renewed commitment to social accountability as a guiding principle. The path forward does not lie in rejecting global engagement, but in ensuring that medical education remains accountable first and foremost to the populations it is intended to serve.

## Declarations

## Competing Interests

The author declares that there are no competing interests.

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## Author Contribution

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