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'Partnerships and power in the 2030 Agenda'
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1. Introduction

Over the past four years I have worked as a project manager for the University of Cambridge, overseeing a number of research initiatives that involve African university partners. Through this work I became increasingly conscious of the complexities that exist below the surface of partnerships. Partnerships are an effective mechanism for addressing global health challenges collaboratively, however, there is a dimension to partnerships that is less visible. Partnerships are structured in a way that reflects how knowledge is privileged, and the long tradition of partnering East African research institutions with UK universities carries forward an historic relationship. While global health research is a huge driver of activity at universities in the UK, Uganda and Rwanda, it tends not to be at the core of discussions surrounding the decolonization of African universities, which focuses more on the social science disciplines.

My research questions whether there is a better way for partnerships to be arranged, conducted and conceptualised. It is also premised on the view that a deconstruction of partnerships is essential to leave out-dated structures in the past, and allow for more equitable relations throughout the research partnership process. This would benefit researchers and institutions involved, as well as the global health research sector more broadly. By focusing my research on the partnerships between the UK, Uganda and Rwanda it considers whether, and if so how, historic colonial links are relevant, since Uganda is a former colony of the UK whilst Rwanda is not; it is as a former colony of Germany and Belgium.

Studying global health research partnerships is important for three key reasons. Firstly, addressing the health challenges of populations requires expertise and resources of individuals and institutions from across the world. It is important to ensure that when institutions go into partnership, that these linkages are effective in balancing the priorities and roles of multiple partners. Secondly, if the methods and practices of these partnerships are built upon colonial legacies and historically imbalanced relationships, they need to be scrutinized to assess whether they recreate and perpetuate such legacies and imbalances. If scrutiny does shows a link between partnerships and neo-colonial practices, global health research must be implicated in the current decolonization movement for postcolonial Africa. And thirdly, since the seventeen United Nations Sustainable Development Goals are specifically dedicated to health (goal #3) and partnerships (goal #17), there is a heightened global concern with both healthy lives for all and unlocking the transformative power of partnerships for sustainable development. Therefore, this research is important as it looks at the nexus of these particular goals, helping to identify the methods of how best to achieve good health and global partnerships in the future.

2. Global Health Research Partnerships

Global health research is an economically powerful and rapidly growing sector, with no indication of slowing down. Today, the global scientific research community consists of over 7 million health researchers that account for a combined research and development spend of over $1 trillion (which represents a 45% increase since 2002), and who are publishing in around 25,000 separate scientific journals per year[1]. Researchers go into partnership with others, motivated by working with the very best talent and facilities in the world, and also motivated by curiosity, seeking new knowledge to advance their field or to tackle specific problems.

The first global health partnerships between universities developed from the practice of Northern institutions obtaining samples and data from Southern sites. Partnerships most often involved those in the North and Northern scientists and administrators based in Southern institutions. Later, partnerships involved Northern researchers traveling to a developing country to collect samples, or were designated sites with expatriates based in Southern countries. Although many of these partnerships involved capacity building their structures were inequitable[2].

Over the last 20 years there has been an expansion in the popularity, nature and scale of global health research partnerships. Particularly noteworthy is the South-South partnerships and networks as well as international consortia[3]. These new models signal a growing and increasing reliance on partnerships as the medium to achieve equitable research in an increasingly globalising world (Academy of Medical Sciences 2012).

Because global health research partnerships between research institutes in the UK and East Africa take many guises (see Figure 1) – including individual-individual partnerships, institutional level partnerships and consortia – is it difficult to quantify the exact number of partnerships that are on-going. However, what is evident is the extent of investment from the UK in these partnerships. Between 2014-15, the UK government spent £95 million in Uganda via its Department for International Development (DFID), and £77 million at DFID Rwanda[4]. Additionally, the aim of the UK Government's Newton Fund is to develop science and innovation partnerships that promote the economic development and social welfare of partner countries. Launched in 2014, its annual spending allocation for partnerships around the world was £75 million, which will reach a level of £150 million per year by 2021. These sources of funding show that global health research partnerships are significantly supported by major economic structures particularly from the UK.

[1] (Academy of Medical Sciences 2012) 'Building Institutions through Equitable Partnerships in Global Health: Conference Report'. Available at: http://www.acmedsci.ac.uk/policy/policy-projects/global-health-partnerships-and-capacity-building/ [Accessed August 16, 2016].
[2] Ibid
[3] Ibid
[4] (DFID 2016) *Annual Report and Accounts 2015-16*, Available at: https://www.gov.uk/government/publications/dfid-annual-report-and-accounts-2015-16 [Accessed August 16, 2016].

Figure 1.
Source: Academy of Medical Sciences (2012)

Type of partnership	Advantages	Disadvantages
Individual to Individual	• Personal choice and commitment. • Mutual benefit for both researchers. • Flexible. • Cost effective.	• No direct institutional strengthening. • Benefits only individual researchers.
Institution to institution	• Sharing resources can be of benefit to both institutions. • Can provide continuity that is not dependent on individuals. • Establishes a framework for research capacity development. • Can establish clear agreements on sensitive issues such as data sharing, IP and publication. • Facilitated by new communications technologies.	• The partnership can be dominated by one institution. • Individual researchers may be pushed into 'forced marriages'. • A formal, time-defined agreement can tie one or other partner into a long-term, unproductive relationship. • Termination of the partnership can be difficult and have wider consequences such as an impact on broader relations between institutions.
Consortium or network	• Prevents duplication of research. • Allow sharing of ideas without fear of competition. • Provides increasing opportunities for Southern leadership.	• Too much investment can go into maintaining the infrastructure of the consortium. • Can stifle scientific competition and inventiveness. • Can cause tensions between partners who do not agree with the 'consortium's view'.

While global health research receives this enthusiastic support from the international community, my research is interested in investigating how knowledge is structured in such partnerships, and what imbalances occur beneath the surface.

3. Examples of Problematic Research Methods and Practices

Drawing on insights developed through reflection on my professional experience, particular methods and practices of global health partnerships contribute in creating or entrenching problematic inequalities between partners. Specifically, these include Memorandums of Understanding (MOU) and Standard Operating Procedures (SOPs).

Using a MOU is the most common and trusted method to formalise partnership agreements between institutions in the UK, Uganda and Rwanda when formalising partnerships of any type. The MOU is widely used by universities and governments as well as in the corporate world, as a legal document to articulate a business or collaborative relationship formally. The function of the MOU, in the context of global health research, is to have all parties agree on the conditions of their partnership and maps out how funding for studies will be channelled[5]. It also contains details

[5] (Musoke et al. 2016) Nottingham Trent University and Makerere University School of Public Health Partnership: Experiences of Co-Learning and Supporting the Healthcare System in Uganda. *Globalization and Health* 12 (1). Available at: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-016-0148-x [Accessed August 22, 2016].

pertaining to the sharing and ownership of intellectual property. It is worth considering how this legal framework reflects the political nature of partnerships. For example, the fact that an MOU is required and repeatedly used reinforces the constant need to balance power and uphold equality, safeguarding the actors involved from unfair terms that could come about from activities that are one-sided in benefit and direction. One trend in addressing the challenges for global health is to re-envisage health as a right to be accessed universally by all. The MOU represents an extension of this will as its purpose is to agree on mutual benefit among partners. It has a top-down structure, involving a national legal system under which the agreement is valid and requires top-level signatories and named academic co-investigators. However, it is important to assess whether the horizontal relations in partnerships that MOUs formalise and confirm, are contradicted by the vertical hierarchy which the MOU procedure crystallises. It is a framework that implies an objectivity and equality given the presentation of partners on the paper, but is produced through a vertical and possibly unequal process and format.

Similarly to MOUs, Standard Operating Procedures (SOPs) are commonly used in global health research partnerships, as well as in the corporate world, to ensure a service is delivered consistently and within the industry relations and laws. In a setting where a health research study is taking place with samples being collected from various sites, the SOPs outline the responsibilities of personnel and the hierarchical management of the research process. SOPs are also used to outline the functions of ethics committees[6], confirming their centrality to the research process at various levels. The World Health Organisation provides templates for acquiring consent from study participants, yet the process for negotiating the terms of the research between the partners and reaching a consensus of agreement on terms of the partnership, are not so explicit. The silencing of this process from the SOP is consistent with its use as a concise guide to the research taking place at the individual study participant level, in accordance with national and international ethics guidelines. But there is a gap between two levels of the research activity, the individual study participants and coordinators on the one hand, and the national and international researchers involved on the other. An assumption that the research is ethically sound, from study participant to partnership relations, may evolve from the external perception that the research is taking place and that science is being delivered. Providing results, study analysis and outcomes could easily be interpreted as a sign that the partnership is working well and is effective in totality. Furthermore, if we think about SOPs as a traditionally used research methodology, we can see that how it allocates roles and privileges certain knowledge in a pattern over time. This could mean that there are less likely to be questions raised about how SOPs might be structuring knowledge due to their routine use. The tradition of using MOUs and SOPs is also noteworthy as together they may help to conceptually structure research in two stages, where different partners have a dominant role in either stage, thus structures hierarchy may be encouraged. Molyneux and Geissler (2008) question whether rules and procedures, such as SOPs, prevent ethical thinking, since the increasing attention to matters of detail, which parallels trends in scientific work itself, distances the research away from the overarching ethical question of whether the research is tackling global inequalities through its methodology and execution.

[6] (Ministry of Health 2009) National Ethics Committee Standard Operating Procedures. Url https://www.daidscrss.com/partners/Page_Regulatory_Management/Docs_Regulatory_Management/Docs_Flag_Forms/Rwanda_RNEC_Final_SOPs.pdf [Accessed 24 August 2016].

Through conducting interviews with those involved in partnerships, I hope to gain access to MOU and SOP documentation for corresponding partnerships. By analysing the rhetoric and structures referred to by the documents, and comparing them with the accounts of interviewees, I will be able to assess whether or not there is a disconnect between formalised and actual partnership relationships tied to the development of these research frameworks.

4. Expected issues to be unravelled by interviews

By conducting interviews with Ugandan and Rwandan researchers involved with global health research partnerships, I expect a number of points of interest to develop.

It may be that the enormity of the global health research sector is so great that it inhibits the development of a more varied or context specific local research agenda. Interview responses may demonstrate that the production of scientific knowledge is widely regarded as being universal and based upon hegemonic methodologies and epistemologies. Interviews could also demonstrate that the trend to tighten oversight of individual study sites to uphold ethical research practices and to minimise human rights abuses in science (Molyneux & Geissler 2008), might contribute to a neglect of the process of partnership and collaboration.

My research methodology allows for the formalised and informal structures to be analysed, as well as being open to the voices of researchers from multiple sides of the partnership.

5. Conclusions: Is there a need to decolonize global health research partnerships?

Assessing the balance of power between the actors involved in global health research partnerships, and also how knowledge is privileged in research, is vital if this well-funded tradition is to continue to characterise academic collaborations.

The buzzword of 'partnership' is being more commonly used, particularly in relation to international linkages. Some may question whether the connection between imbalance and inequality is actually problematic for partnerships, if an imbalanced partnership produces scientific results. However it is the very conception of partnership which prescribes a mutually negotiated arrangement that is commonly agreed upon and beneficial for all. It is imperative that the rhetoric of partnership does not conceal imbalance or inequality, which would contradict the very meaning of partnership, and could contribute to exploitation.

In his *Decolonising The Mind*, Thiong'o (1986) emphasises that imperialism has the ability to annihilate people's belief in their capabilities and ultimately themselves, and continues to control the economy, politics, and cultures of Africa. The current decolonization movement questions whether African universities still suffer from a colonialism of the mind (Adriansen 2015). It has also helped to reveal that implicitly unequal relationships and traditions can alienate African intellectuals (Thiong'o 1986) as they struggle to participate in a discipline which at its core privileges a dominant knowledge and perspective that they are disadvantaged from accessing.

Uninterrupted, the perseverance of dominant western scientific knowledge and the privileged research agendas from Northern institutions, could be continuing what Connell (2007) calls the 'pain of colonialism', where the dominant powers close down, rather than open up, the self-knowledge of society.

If there is a true global will for equity, democracy and collaborative working towards finding solutions to the biggest threats to human health, then there must be a true global will for challenging inequality and homogenous approaches.

Partnerships have the potential not just to perpetuate neo-colonial relationships, but to be a catalyst of change within which to establish truly equitable collaboration, by being open to the non-dominant theories of knowledge. Decolonized global health research partnerships may involve the deconstruction and then reconstruction of the sources of knowledge that are relied upon. Partnerships are therefore well placed to challenge and change problematic or harmful methodological concepts and instruments. By offering such an analysis, such as what my Masters research seeks to explore, intellectual projects can advance the value of research in a globalizing world that is composite of diverse knowledges, cultures and histories.

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