Background paper

Reimagining research partnerships: equity, power and resilience [1]

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The background paper key themes and questions are summarized in this video:

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1. Abstract

Global health research partnerships are a dominant strategy for advancing scientific knowledge, technological innovation and improving health outcomes worldwide. Successful navigation of such relationships is a highly complex endeavor, owing significantly to interpersonal, institutional, national and international factors. Research partnerships occur through various kinds of formal and informal collaborative arrangements which are often particularly influenced by asymmetries in power and differences in epistemologies, context, and scientific culture. Partnership-based global health research can involve relationships between many kinds of stakeholders – academic institutions, health research funders, pharmaceutical companies, branches of national governments, and non-governmental organizations, amongst many others. Regardless of partnership type, disparities – financial, material, infrastructural, epistemic, and the like – are not only a downstream effect of systemic inequities that influence partnerships but also shape partnership inputs, processes, and outputs that further sustain and perpetuate these inequities. With increasing recognition of these asymmetries in global health research partnerships, a multitude of guidelines, principles, and recommendations have been developed to promote and protect fairer and more equitable partnership practices.

This year, the Global Forum on Bioethics in Research (GFBR) will focus on ethical challenges pertaining to research partnerships with 'equity' and 'power' as essential considerations that may relate to further constructs like 'resilience'. For this discussion, *global health research partnership equity* is loosely understood as an ideal state in which certain imbalances in power between research partners are deliberately addressed through efforts to prioritize fair and mutually beneficial sharing of the inputs, processes, outputs, and impacts of research endeavors. This typically requires concerted attention to identifying and prioritizing potential equity-promoting actions proportionate to needs, defining and pursuing implementation strategies, and agreeing upon processes for measuring or monitoring progress. A central goal of this GFBR meeting is to shift the discussion beyond identifying inequities or injustices in research partnership practices, to creating solutions that are ethically justified, pragmatically operationalizable, and which may radically reimagine how we define and approach research partnerships as a global community.

2. Purpose

This paper is being published with the 2025 GFBR call for participants and presenters. It provides background information and further details on the Forum topic and scope. Proposed presentations may relate to the themes in this paper or other issues that present **ethical challenges or solutions pertaining to equity, power, or resilience in research partnerships.** Presentations should be relevant to research collaboration that occurs either within the global South or between the global South and global North. Moreover, case studies can address, but are not limited to, one or more topics discussed in the '**Questions to Advance Understandings of Ethical Research Partnership**' section. Terms such as 'fairness' and 'equity' are intentionally used quite broadly to describe how power, resources, and opportunity are distributed between unequal actors.

GFBR is seeking three types of presentation proposals:

- **Real-life case studies of research partnerships** that deepen understanding of ethical challenges, demonstrate the development of good practices and/or share experiences of using experimental approaches to research partnership. Cases that only state ethical challenges encountered in research partnerships will be received with lower priority, as these are already well documented in the literature. Case studies should move the discussion forward.

- **Conceptual and normative papers** that provide in-depth ethical analysis related to the topic.

- **Papers that address governance or policy issues** that relate to the topic (e.g., focusing on institutional, national, regional or international regulation, guidelines, policy, principles or issues associated with research ethics review or other governance bodies, mechanisms or tools).

This paper has two major entry points in the framing of equitable global health partnerships structured as five broad themes and sets of questions. Within each theme, first, it discusses research partnerships in relation to a broader range of literature including global health, bioethics, development, and history. In doing so, the paper brings into sharper focus how current forms of partnerships in global health emerged in particular contexts. The paper also draws attention to the interconnectedness of partnerships to larger global historical practices, framing partnerships as part of worldmaking processes. Second, this paper describes many of the internal dynamics of partnerships, including relational, structural, and institutional practices of partnerships, with a specific focus on equity-related processes. By highlighting these practices, it draws attention to how equity as both a value and principle could be recognized as an ethical standard in practice.

Defining who is considered a research partner is also an area of interest to the Forum. Traditionally, the focus has been on power imbalances, or structural inequality in relationships and obligations, between actors responsible for conducting research activities, such as researchers and research institutions. This is often distinguished in the literature from obligations researchers have toward research participants and communities; and sometimes distinguished from the roles and responsibilities of research sponsors and other invested parties (e.g., government authorities). While acknowledging such historical distinctions, this GFBR meeting is keen to challenge such divisions and explore the relationship between different actors that have critical roles to play in the successful implementation of ethical and equitable research partnerships.

Lastly, terms used to describe power and resource differentials within research partnerships vary, each with its own strengths and limitations. This includes dichotomies such as low- and middle-income country (LMIC) vs. high-income country (HIC), global South vs. global North, developing vs. developed, third-world vs. first-world, central ideology vs. peripheral ideology, dominant vs. marginalized, low-resourced vs. well-resourced, advantaged vs. disadvantaged, or majority world vs. minority world. How people and places are categorized matters, and such terminology is never neutral (see discussion by Khan et al. 2022). The global health partnership equity literature has predominantly discussed issues

with the use of HIC vs. LMIC terminology; however, this framing can inadvertently reinforce artificial constructs of power based on geography or nationality which ignores the dynamics of collaborations between two or more HICs, between two or more LMICs, and sub-national research efforts. It also obscures the considerations of conducting research with and for Indigenous, Aboriginal, Native, and First Nations Peoples – communities that exist within national borders but have sovereign systems of identity and governance. It also naturalizes that some countries are high-income, and others are not, without drawing attention to why this is the case. Many of the other terms also make inherent assumptions about how less powerful groups and research partners see themselves and aggregates them with others whom they may otherwise have little in common – developing, peripheral, marginalized, low-resourced, or disadvantaged. These depictions may be more or less accurate, depending on the circumstances, or when framed against specific points of reference. For example, many capital cities in LMICs or other areas of urbanization have a preeminent university or academic system. Relative to some academic institutions in HICs, these institutions may be considered low-resourced due to differences in finances and administrative capacity. However, relative to smaller or rural academic centers within the same country, they are considered well-resourced. Given this complexity, this paper has elected to mainly use the terminology of global South and global North to loosely define the relative positions of power and resources within a research partnership. This is to ensure the discussion is not limited to transnational research given Southern settings exist within high- and middle-income countries while pockets of the global North exist in low-income countries. This also avoids a rigid definition of what establishes the power differential between groups (economic, material, political, etc.) as these dynamics can, and do, play out differently within research partnerships (Contractor and Dasgupta 2022). We encourage presentation proposals to invoke alternative terminology if there are other descriptors of power axes better suited to the discussion and to clearly describe the context or frame of reference in which the terms are used.

3. Overview

The focus on equitable global health partnerships has been steadily increasing for the last two decades. In part, this awareness is related to international investments in HIV, malaria and other infectious disease research, along with increased funding for genetics and genomics research, amongst other reasons (Parker and Kingori, 2016). Striving for research partnerships that are fair and equitable has a much longer history, rooted in international relations and developments after World War II, as formerly colonized countries started to gain independence (Amrith, 2006). International attention increasingly focused on social and economic inequalities between countries, generally, although not exclusively, between those in the global South and North. One explanation for inequality was that countries considered part of the global South lagged behind, developmentally and technologically, and would require assistance from wealthier parts of the world considered to be in the global North (Ferguson 2005; Rist 2008; Bhambra 2015)[2]. Moreover, proponents of this view argued that health inequities, and specifically the poor health outcomes of populations in the global South, drove poor economic outcomes. If these countries and communities improved the health of these citizens, this would lead to greater “development” and economic growth (Packard, 1997).

Indeed, it was only a few decades ago that global leaders officially recognized that merely 10% of the money spent on health research and development was focused on diseases affecting 90% of the global population, better known as the 10/90 gap (Global Forum for Health Research, 2011). This was popularized in the first decade of the 2000s but first articulated back in 1990 based on a Commission on Health Research for Development (COHRED) report, *Health Research: Essential Link to Equity in Development* (COHRED 1990*)* which emphasized the relationship between research and development, with international partnerships framed as the key model for advancing global health research. Since this

[2] Importantly, these ideas were epistemology supported by theories of modernization (see Rostow 1960 and Levy 1965 for example). Yet, at the same time, anti-colonial and dependency scholars were clear that inequality was a result of colonial extraction as a function of this history (see Frank Gunder and Walter Rodney for example).

report, the last few decades have seen a major increase in funding for health research in the global South (COHRED 1990; Crane 2013). Furthermore, the report stressed that the development of countries with low economic indices, or those recently decolonizing, was only possible if investment in health research was increased significantly in those locations.

As part of situating contemporary research partnerships, it is also important to understand various actors that were critical for promoting particular kinds of partnerships. Historically, partnerships were primarily bilateral. Towards the end of the twentieth century, these configurations began to change. Under the auspices of the World Health Organization (WHO), which was charged with coordinating global efforts of disease management and control, health research became increasingly important as a key tool to determine health interventions worth pursuing globally, but in global North settings in particular (Weisz and Tousignant: 2019). During the 1970s and 1980s, the political demands of newly politically independent states combined with global economic shocks meant that institutions like the World Bank became increasingly influential in determining what health was and how it could be achieved (Birn et al. 2017). Many parts of the global South continued to struggle with the impact of colonialism, unequal international trade, and disproportionate health burdens (Getachew 2020). Consequently, these economic stressors necessitated many countries in the global South to borrow money from institutions such as the World Bank and International Monetary Fund (Rowden 2013). One of the effects of borrowing was a significant decrease in public expenditure provided by governments, including for health care and research (Rowden 2013). These developments led to parts of the global South being unable to adequately respond to the health needs of their citizens necessitating the involvement of global North actors through partnership arrangements (Gerrets 2015). These actors were no longer just nation-states, but included private corporations, non-governmental organizations, and philanthropic institutions (Buse 2000).

Philanthropic organizations, such as the Gates Foundation, also became increasingly important actors in global health governance (Weisz and Tousignant: 2019). These new configurations meant a variety of actors in the global North now influenced various aspects of health research in the global South, including health research priority setting, which intervention strategies were advanced, where these took place, who was involved, and which systems of knowledge were used to frame scientific understanding (Birn 2014; Weizz 2019). The influence of these economic actors also propelled a more biomedical and technological focus of health interventions (Birn 2017) which has traditionally dominated more local knowledge systems and understanding of health. It also implied that the health of various populations in the global South was subject not only to Southern nation-state actors, but also to a variety of actors in the global North. This arrangement makes it difficult for communities to hold actors in the global North accountable, unlike governments (Clinton and Sridhar 2019).

With this historical framing in mind, it is relatively unsurprising that power imbalance is both a root cause of and perpetuator of scientific and health inequalities embedded in how contemporary research partnerships design, conduct, translate, and disseminate knowledge. Frank asymmetries in material resources, financial support, institutional and administrative capacity, career advancement, research experience, and specialized educational exposure can make gaining, and maintaining, opportunities for research partners based in the global South substantially more difficult (Bump 2015; Gautier et al. 2018). Without sufficient representation and involvement, the research priorities and outcomes of partnerships can be skewed towards benefits for partners based in the global North, without sufficient attention to how ‘benefits’ are contextually understood and defined by partners in the global South (Pancras et al. 2022).

In response to increased recognition and visibility of these imbalances, equity as a fundamental principle for governing research partnerships has gained traction over the past two decades. Health research inherently involves ethical considerations and thus is not ethically neutral (Saenz et al. 2024). Examination of the values that drive research partnership processes and how researchers work with one another is essential. In this context, the phrase ‘global health research partnership equity’ is loosely understood as an ideal state in which certain imbalances in power between research partners are

deliberately addressed through efforts to prioritize fair and mutually beneficial sharing of the inputs, processes, outputs, and impacts of research endeavors. This typically requires concerted attention to identifying and prioritizing potential equity-promoting actions proportionate to needs, defining and pursuing implementation strategies, and agreeing upon processes for measuring or monitoring progress. The foundation for equity (meaning '*aequitas',* a Latin term for justice, fairness and equality) as a principle for health research[3] is historically and commonly situated within theories of justice (Pratt et al. 2014, Pratt 2021). To promote the health and well-being of all communities, particularly those that are marginalized and disproportionately affected by health inequalities, the concept of 'equity' has been extensively debated and focuses on how equity can be realized through social and global justice frameworks. In general, this positive moral relevance and philosophical underpinnings of equity as a principle that corresponds to notions of justice is not contested. However, it is important to consider that many popularized theories of justice are rooted in Western philosophies.

Additionally, in the context of global health research, a strong assumption exists that equitable research practices will not only improve research capacity but also consistently generate more impactful science and meaningful health benefits for communities, compared to inequitable practices. While it is intuitive to believe this, and this very well may be true, to date there is limited (but emerging, see Kok et al. 2017) empirical evidence to support such a claim. Impassioned debates about this matter are likely related to the ambiguity in defining what is an equitable research partnership in the first place (Parker and Kingori, 2016). It is also important to note that health research partnerships have ethical valence for reasons beyond direct impact on health outcomes. Ethical consideration is needed with respect to the impact of partnerships on, for instance, the lives and careers of researchers and research project staff; the structures, policies, and processes of research institutions, as well as their capacity to initiate and sustain research activities; country-specific research agendas; and the geopolitical and economic implications for participating countries involved.

With this complex historical, conceptual, experiential, and theoretical backdrop, a range of operational concerns have been articulated, with increasing normative influence (Costello et al. 2000). 'Parachute' and 'helicopter' research – where research in the global South is conducted and published by investigators from the global North without meaningful involvement or recognition of local collaborators, or that lacks utilization of existing research infrastructure in the global South – is now widely discouraged (Horton 2018; Nuffield 2020). There is a growing wealth of observations of inequities, although so far limited to partnership case reports (Plamondon et al. 2021), thematic analyses of qualitative stakeholder assessments (Faure et al. 2021), and demonstration of unjust bibliographic trends (Cash-Gibson et al. 2018). These depictions capture only small parts of existing research partnership practices. The pluralistic, subtle, and entrenched nature of these issues can make it difficult to develop pragmatic, evidence-informed interventions that meaningfully promote transformative change.

Nonetheless, numerous attempts have been made to find commonalities in underlying research partnership approaches. There are now over a dozen sets of proposed principles and guidelines for equitable health research partnerships (see Appendix A). Recommendations are starting to converge on a consensus of topics (see Table) and several guidelines provide structured toolkits for research partners or institutions to identify practices that promote or hinder equity (see Appendix B). Whether - and how - these translate to actual policy, practice and ultimately improved partnership outcomes remains unknown. There is no agreement on what, if any, measures or metrics of equity can be standardized or if the contexts of partnerships are diverse to the point of requiring a unique assessment.

[3] For discussion on broader considerations of health and global distributive justice within political philosophy, see Caney 2001, Caney 2025, and Pogge 2001.

Table. Themes and topics commonly discussed in the context of equity within international research partnership. Includes a list of comparative values and goals that often overlap with equity to promote strengthened and sustainable partnerships. This table is meant to be representative but not all-inclusive.

Planning Phase	Research Phase	Post-Research Phase		Values/Goals
Access to and allocation of funding	Capacity building	Global scientific visibility		Accountability
Access to global literature/expertise	Communication	Lead authorship		Autonomy
Access to material resources	Fair contributions to data collection	Post-study data access		Capacity building
Bilateral ethics review	Fair contributions to data analysis	Post-study material/technology access		Fair process
Defining roles and responsibilities	Mentorship	Publication language and availability		Reciprocity
Early engagement with all partners	Training early career investigators	Representation at conferences		Respect
Hiring and training of local staff				Solidarity
Leadership				Transparency
Setting a relevant research agenda				Trust
Transparency in objectives/motives				

There is a growing appreciation for what should be done to promote more equitable practices within collaborative research; but as is often the case in global health, the bridge between *knowing* and *doing* is a long one. By promoting further discussion on the ethics of health research partnership equity, the Global Forum on Bioethics in Research (GFBR) aims to move the discussion beyond identifying inequities and injustices in research practices to solutions that are ethically justified, pragmatically operationalized, and which may radically reimagine how we define and approach research collaboration as a global community.

4. Questions to Advance Understandings of Ethical Research Partnership

Geography and Terminology

Historically, global health research partnerships have included collaborations between those in research settings in the global South and North. The term 'global' in this context emphasizes national boundaries as markers of differences within the collaboration. In this framing, questions related to inequalities of resources, power, infrastructure, and skills have been stressed. In response, various understandings of justice, inclusion, and recognition have been advanced as ethical and equitable responses to these challenges. As research partnerships have grown, so has attention to the needs, interests and obligations of researchers, particularly those from countries and regions historically excluded or marginalized in global scientific research. The inclusion of researchers from the global South has resulted in calls for different kinds of models and approaches, as can be seen in the recent movement to 'decolonize global health' (Kwete 2022) and The Cape Town Statement on Research Equity (Horn et al. 2023).

While the global lens is important, we may miss capturing certain challenges when only focusing on partnerships between actors in the global South and North. Increasingly, inequities within countries and regions are surfacing as important ethical challenges. These may result in what can be thought of as 'South-South' (Grey and Gills 2016) collaborations where power and resource asymmetries also manifest. These collaborations are seen as especially impactful because local researchers may be able to prioritize more locally relevant research. A recent literature review found that South-South collaborations are framed around values of solidarity, collective justice, and mutual exchange of benefits (Birn 2019), whereas North-South partnerships follow more Western-dominant objectives of productivity, efficiency, and innovation. Some of these claims, however, have been contested, demonstrating the complexity of the issue and the risk of losing important contextual insight in the pursuit of generalizable claims. For example, Ordóñez-Matamoros et al. show in an analysis of research outputs in Colombia that Colombian research teams collaborating within South-South partnerships reported a higher volume of scientific production, while those collaborating within South-North partnerships contributed more to local knowledge systems and understandings of health (Ordóñez-Matamoros 2020). Additionally, partnerships within countries, including wealthy countries in the global North, also require ethical reflection. For example, structural challenges related to the privatization of health research and public-private partnerships continue to surface (Ruckert and Labonté 2014; Plamondon et al. 2021). While general ethical issues such as research benefit, harm reduction, and autonomy arise, there is also evidence of structural coercion, with trials and other experiments drawing on vulnerable populations (Fisher 2013).

While both of these challenges are important, a third possibility is also to see how these issues are connected. Local challenges may also be interconnected with larger geopolitical issues at play, influenced by global histories, economic policies and systems, or cultural contexts. To this end, the value and importance of equity seemingly apply to all research partnerships whether they are North-South, South-South, or North-North. However, the historical context of inequalities continues to shape partnerships differentially. This means that a universal notion of equity may not take into account specific dynamics including asymmetrical power imbalances. A nuanced analysis is necessary to appropriately define and apply equitable practices in each context.

<u>Questions:</u>

- Is 'partnerships' still the most relevant and appropriate term to describe the dynamics at play in how collaborative global health research is conducted?
- How should different kinds of partnership models be evaluated (i.e., North-South, South-South, North-North, South-North-South), and should the historical context of partnership models inform/influence such ethical assessments?

- How should we define partnerships between geographic regions, considering existing perceptions in global health literature—particularly the distinctions between high-income countries (HICs) and low- and middle-income countries (LMICs)? Should such definitions address material and discursive inequities, and employ aspirational language and models aimed at overcoming existing disparities without running the risk of re-inscribing inequities?
- As an academic matter, the literature on 'global health research partnership equity' and 'decolonizing global health research' are both dominated by lead researchers in the global North. What does this mean in terms of the validity and representativeness? What values, theories, and knowledge systems should inform further development of this as an academic space? Are there trade-offs and when are these ethically justifiable?

Economics and Politics

Partnerships in global health research are enmeshed in complex political and economic relationships (Plamondon 2021) and equity (or inequity) within research partnerships re-makes and influences these relationships (Murphy 2015). For example, there have been increasing calls for more global health research partnerships to assist with the provision of healthcare for the host communities (Molyneux 2012, Kamuya 2014). Often these claims are made by communities themselves citing principles of distributive justice, solidarity, and reciprocity as reasons to support the health and wellness of those who have participated in research and contributed to global scientific knowledge that presumably benefited someone somewhere in the world (Adhikari 2019). While this has meant that communities may gain access to critical healthcare services, there are important questions about the pragmatic limitations of developing healthcare systems that are heavily reliant on research, such as sustainability and feasibility. What happens when collaborations end, or funding runs out? There are also ethical concerns related to how research participants or communities become dependent on international collaborations when citizens cannot be held accountable and whether this model – which reinforces global historical inequalities, power asymmetries, and stereotypes such as superior 'donors' and inferior 'recipients' – can ever actually demonstrate respect for persons and communities in its pursuit of reducing health disparities and suffering (Petryna 2009, Benton 2015).

Researchers and research institutions face similar challenges, relying on partnerships for employment and to cover research costs, without which health research would not be able to occur. In some instances, budgets for HIV research provided by external funders eclipse entire national healthcare budgets (Nyugen 2010, Wintrup 2021). In this way, partnerships are part of re-making political and economic relationships, which shift mechanisms of accountability and power to developing more just and appropriately responsive systems.

<u>Questions:</u>

- What is the interplay between development and scientific research concerning mechanisms of accountability or feasibility of equity in research partnerships?
- In what ways do these connections promote or limit access to healthcare in under-resourced settings?
- Do partnerships, by definition, promote mechanisms of economic or health dependence for partners in the global South by sustaining connections and collaborations with the global North?
- In what ways could research funding and sustainability of research partnerships become less dependent on geopolitical and economic interests?

Responsibility and Accountability

Accountability in global health research partnerships serves as a fundamental mechanism to keep dominant power structures 'in check'. The concept of accountability in global health

research is complicated by the complex relationships between multiple stakeholders, which introduces questions of framing: *to whom, by whom, for what* and *how* (Bruen et al. 2014; Liwanag et al. 2023). Principles that underly the importance of accountability include transparency, honesty, integrity, and commitment to governance and change based on the input of others (Montreal Statement 2013, TRUST Code of Conduct 2018). It is worth thinking about accountability for the multifactorial influences on research partnership equity through a lens of actors outside of the partnership (i.e., 'external accountability') and between research partners or institutions (i.e., 'internal accountability'). Equally important to reflect whether such relationships are best served with unilateral mechanisms of accountability, which tend to follow problematic default positions of authority and power, versus envisioning a system built upon multi-directional exchange of responsibility.

Global health actors traditionally considered 'external' to research partnerships – such as research funders, global health journals, health ministries, and international governance agencies – represent structures that hold influence over how research and research partnerships are conducted. These tend to be unidirectional with the partnership held accountable *to* the external structure, and usually *by* the external structure, via pre-conceived mechanisms and procedures. These external structures and accountability mechanisms can cause tension with other equity-related partnership goals or objectives. For example, research funders, who are most frequently based in the global North, often hold significant influence over the research agenda, design, and implementation, which may or may not align with priorities and capabilities within the global South (Finkel et al. 2022). This draws on competing values that the partnership needs to balance – the stewardship of health research funding as a limited resource (with research study area and data often outlined and monitored by a sponsor) versus transparency and responsibility to research communities to reflect their needs and interests in the research design and to make the results of research accessible.

The role of funders in further promoting equitable research practice is still being actively explored (Charani et al. 2022), including the specific role of 'philanthrocapitalist' models (Birn 2014). On the one hand, there have been more globally accessible calls for research proposals and dedicated funding opportunities for investigators based in the global South, while on the other, the imposed retreat of major sponsors in health, such as the U.S. Agency for International Aid (USAID) poses abrupt but timely questions surrounding the viability and accountability of partnerships dependent on unilateral funding. Increasingly, funders are also requiring a demonstration of research capacity-building efforts within proposed collaborative research agendas (Maher et al. 2020), though such components are often still underfunded.

Similarly, global health journals have been criticized for contributing to inequitable processes in disseminating knowledge generated from global health research, including exploitation of academic interests to extract free labor in service of generating profits for a very small number of corporate publishers, under-representation on editorial boards and higher barriers to publication and access for scholars from the global South (Melhem et al. 2022, Ghani et al. 2021). However, there are some trends to suggest journals are increasingly trying to promote equitable practices, such as rejecting manuscripts for research conducted in, but not (co-) authored by contributors from the global South. Some publishers, such as *PLoS, Lancet,* and *BMJ* feature a reflexivity statement for authors to describe how partnership equity has been promoted in the efforts that produced the research for transparency in the contributions each author and institution made to the research and to mitigate tokenistic or 'ghost' authorship (Morton et al. 2022, Saleh et al. 2022).

Identifying areas of concordance and overlap between guidance for partnerships and guidance for these larger global authorities (Jumbam et al. 2021) is important and has the potential to work in tandem toward a common goal. Meanwhile, how these larger structures are held accountable, and to whom, is nebulous at best. Research partnerships can also be held to

account by the communities and individuals who participate in the research, with democratic values dictating that partnerships have certain obligations to ensure community participation regarding the research objectives and potential impacts. Unlike other external systems, the processes for individuals and communities to hold research partnerships accountable are often poorly defined. This also suggests there are differences between how accountability works in relation to individuals compared to institutions. Individual researchers may want to act in particular ways, but the institutions they represent often determine (which can have either or both enabling or constraining effects) how effective accountability mechanisms can be.

Researchers rarely work as independent contractors and most often are affiliated or employed by research institutions, including universities, private research firms/councils, pharmaceutical companies, branches of national government agencies, and non-governmental organizations. Often, these institutions have policies, norms, and standards that serve institutional interests. This requires researchers within a collaboration to function under differing expectations, sometimes in conflict with or to the detriment of the other partner. Examples of these policies include disproportionate allotment of indirect costs between institutions based in the global North versus global South (Crane et al. 2018) and professional advancement metrics that favor institutional self-promotion over collaborating and supporting others (Hedt-Gauthier et al 2018). Mechanisms for institutions to evaluate and monitor the risks and benefits of research for participants are well established through Research Ethics Committees and Data Safety Monitoring Boards. Is it worth considering broadening the scope of these committees, in particular the scope of Research Ethics Committees, to include the evaluation of research partnership practices, or worth establishing an equivalent governance mechanism through research sponsors or institutions to monitor and report fair partnership outcomes; rather, should this be the domain of far more disinterested entities?

The absence of external or institutional mechanisms for monitoring equity-related processes and policies within a research partnership seemingly leaves the initiation, evaluation, and sustainability of these efforts to researchers' interests and self-determination. One potential approach is the integration of evidenced-based equity tools and reporting during research checkpoints. If, at a minimum, widely institutionalized and appropriately standardized equity expectations could theoretically become an ingrained part of how research is conducted. These toolkits also mostly rely on input from all partners, which, in theory, democratizes the process and allows for multi-directional mechanisms of accountability. However, a critical interpretive synthesis analyzing published articles describing how partnerships collaborate found that most attempts to evaluate the equitability of their practices resulted in perpetuating stereotypes of unilateral accountability spanning the 'superior' global North partner as the leader and exemplar, and 'inferior' global South partner as needing to improve to the standard expected by their collaborators (Plamondon et al. 2021). Evaluating research partnership equity also relies on a significant investment from research partnerships themselves, which is difficult when there are countless competing interests for time and resources. Despite over a dozen research partnership equity toolkits currently available, there is no clear evidence that using these toolkits results in strengthened or more resilient partnership practices or outcomes. This comes with the notable caveat that the absence of data should not be interpreted as these toolkits being ineffective, but rather that piloting these toolkits and reporting on the experience is needed (Modlin et al. 2025).

<u>Questions:</u>

- What aspects of research partnership equity are 'quantifiable' or 'measurable'? How can they be monitored and incentivized?
- There are criticisms that checklists and indicators are intrinsically colonial mechanisms used to exert dominance and authority (Chaudruri et al. 2022). Does this mean they should not be used in evaluating the integrity and quality of research partnership equity

in global health? What are the trade-off and values that support using versus not using checklists in this setting?
- How ought different actors have differentiated responsibility for ensuring more equitable collaborations? Which values and processes should inform this?
- Are current ethical theories and approaches sufficient to account for complex histories and research partnerships in different contexts? If so, which theories are useful? If no, what other theories, disciplines and approaches may be required?

Emergencies

Public health emergencies raise unique research ethics questions owing to the pressing need for efficiency and a significant increase in risk to human life (WHO 2020). During such emergencies, there are additional obligations, especially in - but not limited to - the context of research within under-resourced settings, such as avoiding the redirection of resources away from emergency response efforts, having more stringent practices around informed consent to prevent therapeutic misconception, and enhancing protections to ensure participation is voluntary and that research participants are appropriately compensated (Nuffield 2020). It has been argued that research during public health emergencies is ethically mandatory provided there are unanswered questions that will meaningfully impact peoples' current and future lives (Nuffield 2020). But when there is urgency to establish research, this raises questions about the feasibility and relevance of partnership, and partnership equity. What aspects of partnership equity are essential for the conduct of *any* research? What aspects should be deprioritized for the sake of expediency and efficiency within a public health emergency or to maximize benefit or minimize harm? At what point during an emergency should these priorities be re-evaluated?

Plans for partnered research should be reviewed and agreed upon before starting, finding a path forward that is mutually beneficial and meets the expectations of all partners. Factors include but are not limited to, establishing leadership, planning the research design, timeline, data collection, and data sharing procedures (with cultural sensitivity and appropriate involvement of the community, if feasible), determining who will conduct the analysis, and budgeting for who receives financial support from the project and how research funds are allocated. Many of these processes can take time - which is a key and limited resource during a public health emergency. It may be that in some settings, these objectives need to be delayed and revisited later if risks to the well-being and lives of individuals are increased because of a requirement to establish these forthright. However, this assumes that research collaboration is being established in areas and amongst individuals where no previous infrastructure or terms of interaction exist. Especially in the wake of globalized research and disease surveillance during the COVID-19 pandemic (Simpson et al. 2020), existing research partnerships and relationships currently stretch to many, if not most, corners of the world. These are vitally important to invest in, maintain, and strengthen during "quiet" times, as an optimization measure for pandemic preparedness. This can serve to maintain research partnership equity as they already have established partnering practices and policies in place.

<u>Questions</u>:
- What are some examples of research partnership models that have effectively facilitated responses to public health emergencies and how do they promote equity?
- How does the risk of future public health emergencies underscore the need for capacity building in the global South? Who is responsible for investing in and developing this capacity?
- In light of future public health emergencies and current epidemiological data and forecasting, which values do we prioritize now in developing partnerships?
- How and when do public health emergencies justify a re-evaluation of balancing or prioritizing competing values within research partnerships and what should these adjusted priorities look like?

Futures

While global health partnerships are mostly about responding to current health challenges, they also have important implications for the kinds of futures that get enacted. For example, Okeke has shown, in the context of Nigerian laboratory science, how the imaginations of international partnerships shape the future of laboratory science in Nigeria (Okeke 2020). Similarly, Crane et al. have shown how the current underfunding of indirect costs and the administrative burden of managing partnerships erode institutional research capacity in the global South (Crane et al. 2020). This has a significant impact not only on the kinds of partnerships which may exist in the future but also on how research partnerships enable certain kinds of futures while constraining others. Biehl describes how Brazil was one of the first countries to provide antiretroviral treatment to its citizens living with HIV. However, these public-private partnerships also lead with a pharmacological approach at the expense of other health and social interventions (Biehl 2007). Similarly, research partnerships and Ebola vaccine trials in Guinea bypassed historic claims for effective and equitable healthcare and socioeconomic systems (Graham 2019). These examples raise ethical questions about the future of partnerships and the kinds of futures that partnerships enable. When do the ends of short-term health benefits justify the means of bypassing larger structural inequities? Under what circumstances is this revisited, and when (or what) are research partnerships obligated to contribute? What are the realistic limits of these obligations, and who is best situated to step in and fill in the gaps research partnerships cannot fill? Is the principle of respect for persons being met if the research and the systems it facilitates focus so narrowly on one disease or process?

These questions are important for individual partnerships to consider; however, it is also prudent to consider global health partnerships as a collective project, beyond individual health partnerships. Here, partnerships could also be understood in relation to larger socio-political and economic histories. As such, ethical reflection also needs to consider what is the purpose of partnerships in global health? And what kinds of future(s) do specific kinds of partnerships create, while foreclosing on others? Who benefits from those future(s), and who is harmed? These questions suggest that we have to grapple with the larger project of partnerships as both a global health and political project. One example of radical re-thinking of health and political projects is the WHO's report, "Health for All – transforming economies to deliver what matters" (2024). The report provides an example of systemic reorientation of our current economic systems. The report highlights how economic systems must shift towards enabling the provision of health for all, including accounting for the health of the planet. Under this view, the demand is to re-purpose economies towards systems that serve the needs of everyone and the planet against our current system which prioritizes profit for a few, at the expense of both people and the planet. Similarly, ought we re-imagine what partnerships are, what they are about, and the kinds of futures they enable?

Some call for a complete disruption and reformation of academic global health to shift the power from the global North to the global South (Chaudhuri et al. 2021). Under this vision, the need for and role of partnerships then is brought into question if researchers and institutions are viewed as truly global citizens who have the same access to universal expertise, resources, and power. Others argue that solutions need to be sought within the confines of existing paradigms for the sake of generating realistic goals and minimizing morbidity among those already marginalized and under-resourced, who are most likely to suffer in the wake of massive global disruptions to healthcare access (Finkel et al. 2022, Khan et al. 2021, Lawrence et al. 2020). Understanding and defining the types and degrees of power differentials among research partners, as well as determining who holds the authority to define scientific expertise, is a complex, fluid, and highly contextual endeavor.

Elaborating on how partnerships facilitate or limit particular futures, includes how science and knowledge are obtained, created, used, and disseminated by global health research

partnerships. A prevailing critique is encompassed in the concept of 'epistemic injustice' (Bhakuni et al. 2021), namely moral wrongdoing in the creation, perpetuation, or dissemination of knowledge. This undermines the credibility or authority of individuals from the global South who draw from systems of knowing or sensemaking that do not align with the global North (Abimbola et al. 2024). Through the lens of epistemic injustice in global health, research partnership practices – which include the alignment of the research topic with Southern health priorities, designing studies, collecting and interpreting scientific data, and writing and publishing manuscripts – perpetuate the authority and expertise of research partners from the global North. This consideration of epistemic injustice can permeate research at every stage – from inception to translation into health policy and practice.

Lastly, the concept of equity has been a long-standing foundational principle within ethical collaborative global health research. Guidelines for health research in the global South frequently outline collaboration as a research requirement, citing the value of collaboration in reducing exploitation, improving efficiency, maximizing potential health benefits, and promoting capacity building (Emanuel et al. 2004; Saenz et al. 2024). Research partnerships are a type of collaborative research, although it can rightly be argued that not all collaborative research is between partners. Equity then is an intuitive value in research conducted between partners with asymmetric power, in particular, to correct for the historical systems of oppression and disadvantage. While there are some markers of progress; in other ways, the status quo has remained or progress has been reversed, leading to some outward resistance to advancing equity as a core guiding value into the future. This then begs the question, are there other fundamental principles or values that should be considered to govern how research partners should collaborate and interact with one another? For example, respect, dignity, reciprocity, solidarity, trustworthiness, resiliency, and stewardship all have different connotations and associated obligations for researchers, institutions, and other global health actors that may lead to novel ideas to facilitate collaborative research and optimize scientific and ethical progress.

<u>Questions</u>:

- What do you imagine as an ideal future for global health research partnerships? What is needed to realize that future?
- What ethical goals or values should health research partnerships prioritize or aim to achieve going forward?
- How ought these goals and research partnerships themselves be protected during major political shifts (including instances of unilateral decision-making) in power and access on the global stage?
- If a major sponsor reduces or stops providing the means, staff and resources, who should replace its role? Where should these replacement resources come from? How should such dependence be avoided in the future?
- Global health partnerships may inadvertently support or collude with unjust structures and systems. How can partnerships not only avoid this but actively resist complicity?
- Should bioethics be charged with setting the ethical trajectory of partnerships in global health?

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Appendix A: Guidelines for Research Partnership Equity

A Guide for Transboundary Research Partnerships
Commission for Research Partnerships with Developing Countries (KFPE)
Swiss Academy of Sciences
Available at: https://kfpe.scnat.ch/en

Good Practice Document: Four Approaches to Supporting Equitable Research Partnerships
UK Collaborative on Development Research
ESSENCE for Health Research (TDR WHO)
Available at: https://ukcdr.org.uk/equitable-partnership/

Montreal Statement on Research Integrity in Cross-Boundary Research Collaborations
World Conferences on Research Integrity
Available at: https://www.wcrif.org/guidance/montreal-statement

Cape Town Statement on Fostering Research Integrity through Fairness and Equity
World Conferences on Research Integrity
Available at: https://www.wcrif.org/guidance/cape-town-statement

TRUST Code: Global Code of Conduct for Equitable Research Partnerships
European Commission
Available at: https://www.globalcodeofconduct.org/

Principles for Fair and Equitable Research Collaboration
Rethinking Research Collaborative
Available at: https://rethinkingresearchcollaborative.com/the-principles/

Appendix B: Toolkits for Research Partnership Equity

Research Fairness Initiative (RFI)
Council on Health Research for Development
Available at: https://rfi.cohred.org/

Partnership Assessment Toolkit
Canadian Association for Global Health (previously the Canadian Coalition for Global Health Research)
Available at: https://www.ccghr.ca/resources/partnership-assessment-tool/

Equipar Tool
London School of Hygiene and Tropical Medicine
Available at: https://www.lshtm.ac.uk/research/centres-projects-groups/equipar-pilot-evaluation#equipar-tool

The Douala Checklist
University of Yaoundé and Yale Univeristy
Available at: https://doi.org/10.1371/journal.pgph.0001418

The 8Quity Tool
The George Institute for Global Health
Available at: https://doi.org/10.1093/heapol/czad010

Rethinking Research Collaborative
Christian Aid
Available at: https://www.christianaid.org.uk/resources/our-work/rethinking-research-partnerships-discussion-guide-and-toolkit

Equitable Research Partnerships Toolkit
Association of Commonwealth Universities (ACU)
Available at: https://www.acu.ac.uk/our-work/projects-and-programmes/equitable-research-partnerships-toolkit/

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