From the UJMT Consortium of the Global Health Fellows and Scholars Program

DECOLONIZING AND DEMOCRATIZING GLOBAL HEALTH RESEARCH TRAINING: CASE STUDIES

INTRODUCTION

Over the past few years, global health researchers, practitioners, and policymakers have begun paying significant attention to the idea of decolonizing and democratizing global health. This change in the global dialogue has been evident in the medical literature: from zero PubMed-listed publications in 2015 to 38 in 2022. And this number appears to be growing. Acknowledging the controversial aspects of global health's past -- which intersects colonial rule, medical missionaries, and the use of medicine and public health for political purposes -- the movement toward decolonizing global health is placing new emphasis on identifying and removing power structures that stand as obstacles for achieving global health equity.

While this attention is welcome – at the time of this writing – there is no consensus about what decolonizing and democratizing global health means or requires in practical terms. For global health research trainees in particular, this can be a challenge and an opportunity. A challenge, because few educational resources exist, and an opportunity, because it means trainees can wrestle with these difficult concepts, develop their own understanding, and participate in the broader discussion about meaningful change. These cases intend to help foster that dialogue.

ABOUT THESE CASES

These cases were developed for trainees and mentors within the UJMT Consortium of the Global Health Fellows and Scholars Program, funded by the Fogarty International Center and other participating institutes and centers at the US National Institutes of Health. The UJMT Program includes principal and collaborating faculty from the University of North Carolina at Chapel Hill, Johns Hopkins University, Morehouse School of Medicine, and Tulane University– as well as mentors and scientists across 16 countries worldwide.

Cases were developed via a multi-step process. First, we conducted an online survey of all UJMT trainees from 2017-2022. Part of this survey asked trainees to prioritize which content areas they found most important to address in training. Second, we conducted 20 semi-structured interviews with trainees and mentors from the UJMT program. Part of the interview process was meant to elicit real-world scenarios that trainees and mentors have faced related to ethics and colonialism/decolonizing topics. Third, we integrated the survey findings with the interview findings to create cases that reflected high priority issues and real-world scenarios. The four cases here are only the beginning; we plan to add cases over time.

In order to protect privacy and confidentiality, names and locations were changed. In addition, potentially identifying details were modified, and in some instances, certain aspects of the cases were combined from multiple interviews and altered in order to enhance the educational value. Quotations presented are real, or slightly modified for improved language and readability. The cases are meant to confront common challenges and start the discussion about how global health researchers can positively address the interpersonal and structural elements related to colonialism that may influence global health.

SUGGESTED USES

These cases are intended to be used over the course of global research training. Our survey revealed that most trainees preferred to engage in discussions of this type with peers and/or mentors for 60-90 minutes at a time, once every 2-3 months. These materials were designed with that format in mind, though it can be used individually and via other formats and frequencies. We recommend trainees and mentors work to set aside adequate time every few months to work through one case at a time. Where possible, small groups of mentors and trainees could be useful in stimulating ideas and discussion.

Each case includes discussion questions and one or more activities that trainees and mentors can use to be more active and engaged, such as role plays. We emphasize that there is not a singular "right answer" for the questions; the idea is to stimulate open, honest, and respectful discussion. Importantly, some issues that arise may be sensitive or difficult to discuss for certain trainees or mentors. Please be mindful of this. It is perfectly acceptable to skip questions or topics and return to them individually or upon further reflection.

ACKNOWLEDGMENTS

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CASE 1: Access and Ownership of Research Data

LEARNING OBJECTIVES

- **Identify the ethical issues regarding authorship, data ownership, research fatigue, and locally-driven research presented in this case study**
- **Analyze the role that guilt plays in decision-making when faced with an ethical dilemma, and how that relates to your own experiences**
- **Develop and reflect on potential solutions to the described dilemmas**

RYAN is a postdoctoral fellow from a high-income country (HIC) with a PhD in epidemiology who is working in the Philippines researching infectious disease interventions and outcomes. While working on a bibliography, Ryan was surprised to see dozens of publications coming from his research site. He had developed a good relationship with Althea, one of the local physicians. Ryan noticed that Althea and many other locals were listed as co-authors. When he asked Althea about these projects and how the research findings influenced their practice now, she did not know what Ryan was talking about. Ryan quickly realized that Althea was not tangibly involved in the research – other than the fact that her patients' data were being used. Due to paywalls, the local physicians were not even able to access the journal that published the findings. Ryan relates:

I asked them, 'did you know that this research has been prolific?' They had no idea the amount of publications there are about their patients…I thought it was shameful, quite frankly… furthermore, these articles that they do not even know about, some of their names are on them.…[later] I found out that sometimes researchers who had been there in the past had used [local] residents and medical students as translators…and they had listed their names for that reason. But they were not actually a part of the research; they did not know that it was for research…And as clinicians in the country, they were upset that they were used as translators, when they have a higher skill set.

ETHICS ACTIVITY

For this case, in order to spur discussion with a mentor or a peer, we would like you to start on your own. Please rate your agreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree
Althea should be an author on the publication because her patients' data were used.				
Using local residents and students as translators for a research study is wrong.				
The primary responsibility for ensuring research is open access rests with the principal investigator.				
Having publications be "open-access" is critical for improving the social value of research (i.e., the nature and magnitude of the improvement an intervention is expected to have on the wellbeing of patients).				
Paywalls are the single most important barrier to global scientific knowledge access.				

1. Take a moment and discuss with your mentor or a peer where your answers are the same and/or different. What explains these differences?
2. Think a bit more deeply about the issue of paywalls and access to scientific journals. How do paywalls relate to the past and current ways in which global health research is structured?

THE CASE CONTINUES

Ryan felt a lot of distress around how to move forward. On the one hand, he felt like the right thing to do was to bring his concerns up with someone, such as his mentor back in the United States, a local colleague, or even Althea more directly. On the other hand, he worried that bringing up his concerns might be viewed as "critiquing" the status quo or might even create tension for a partnership that was benefitting from the research. And, because he was at an early point in his career, he was concerned about the potential fallout on him from speaking up. He did not want to burn bridges with his mentors, whether in the US or in the Philippines. Ryan struggled with his identity as someone from an HIC, and he had broader concerns regarding the team's relationship with the local community:

> *I did not actually want to be a part of what was happening at that time. I felt like I was on the side of the bad guys, and I did not want to feel like that....[And] research fatigue is a real thing. I was thinking about whether or not it is okay to continue asking people for their time and energy to engage in another survey, or to give us another vial of blood, when they've been doing it for decades.*

DISCUSSION QUESTIONS

1. Ryan wonders about talking to his mentors at institutions both in the US and the Philippines.
   a. If you were Ryan, what would be a good way of bringing up concerns that would not threaten the partnership?
   b. If you were Ryan's mentor in the US, how would you respond, ideally?
   c. If you were Althea (Ryan's mentor in the Philippines), how would you respond, ideally?
2. In this part of the case, Ryan seems to feel guilty about his identity and role as a member of the research team. Have you ever felt this way? Describe the situation, and discuss ways to manage this emotion.
3. Towards the end, Ryan brings up a concern that – although the research seems to benefit the community – it is taking too much time and effort. Can you think of the advantages and disadvantages, both scientifically and ethically, of continuing to partner with the same community for research over time?

THE CASE CONTINUES

Ryan decided to take action by making the previous research findings accessible to the locals through a journal club. There, he shared his bibliography and the research findings that had come from their data. Ryan also decided to intentionally work with a few local colleagues and support their participation in research. During this process, one of his mentees found an area of research that had been neglected by Western researchers and that would truly serve the needs of the local community.

> *One of the junior residents…I think her project highlights the point that if you find something to support that is clinically relevant for local providers, and answers a question that they encounter every day, something that is meaningful on the ground and not just something that is driven by outside resources, it can be amazing! That research project was quite effortless, because the local physicians really owned it. She ended up coming over to the US…and won a young researcher prize. This is what I want my career to be like - we should be working ourselves out of a job!*

DISCUSSION QUESTIONS

1. What do you think of Ryan's solution? Can you imagine a circumstance where a solution like this would work? What about a circumstance where it would not?
2. In the final quote, Ryan highlights the importance that a project be locally driven, as opposed to being driven by outside resources and interests. What are the barriers and facilitators to such an approach in the real world?
3. Ryan takes a strong stand, noting that people in HICs should be working themselves "out of a job." Do you agree with this stance?

TAKE-AWAY!

Think of one lesson from this case that you will take with you in your current and future career.

FURTHER READING

Barsdorf N, Millum J. The Social Value of Health Research and the Worst Off. Bioethics. 2017;31(2):105-115. doi:10.1111/bioe.12320

Summary: Health research should consider both the expected benefits of the research and the priority of beneficiaries, with greater priority given to those who are worse off.

Day S, Rennie S, Luo D, Tucker JD. Open to the public: paywalls and the public rationale for open access medical research publishing. Research Involvement and Engagement. 2020;6(1):8. doi:10.1186/s40900-020-0182-y

Summary: The public has a strong interest in accessing research findings due to their roles as funders, advocates, research participants, and patients; the current publishing system limits accountability, undermines public advocacy and decision-making, emphasizing the need for open-access medical research to involve the public as critical stakeholders.

Koen J, Wassenaar D, Mamotte N. The 'over-researched community': An ethics analysis of stakeholder views at two South African HIV prevention research sites. Social Science & Medicine. 2017;194:1-9. doi:10.1016/j.socscimed.2017.10.005

Summary: The term "over-researched community" is conceptually unclear and is absent from established ethics guidelines, requiring an examination of its meaning. The term represents a composite of ethical concerns, and is often used as a proxy for established ethics concepts; its usage may veil understanding of underlying concerns.

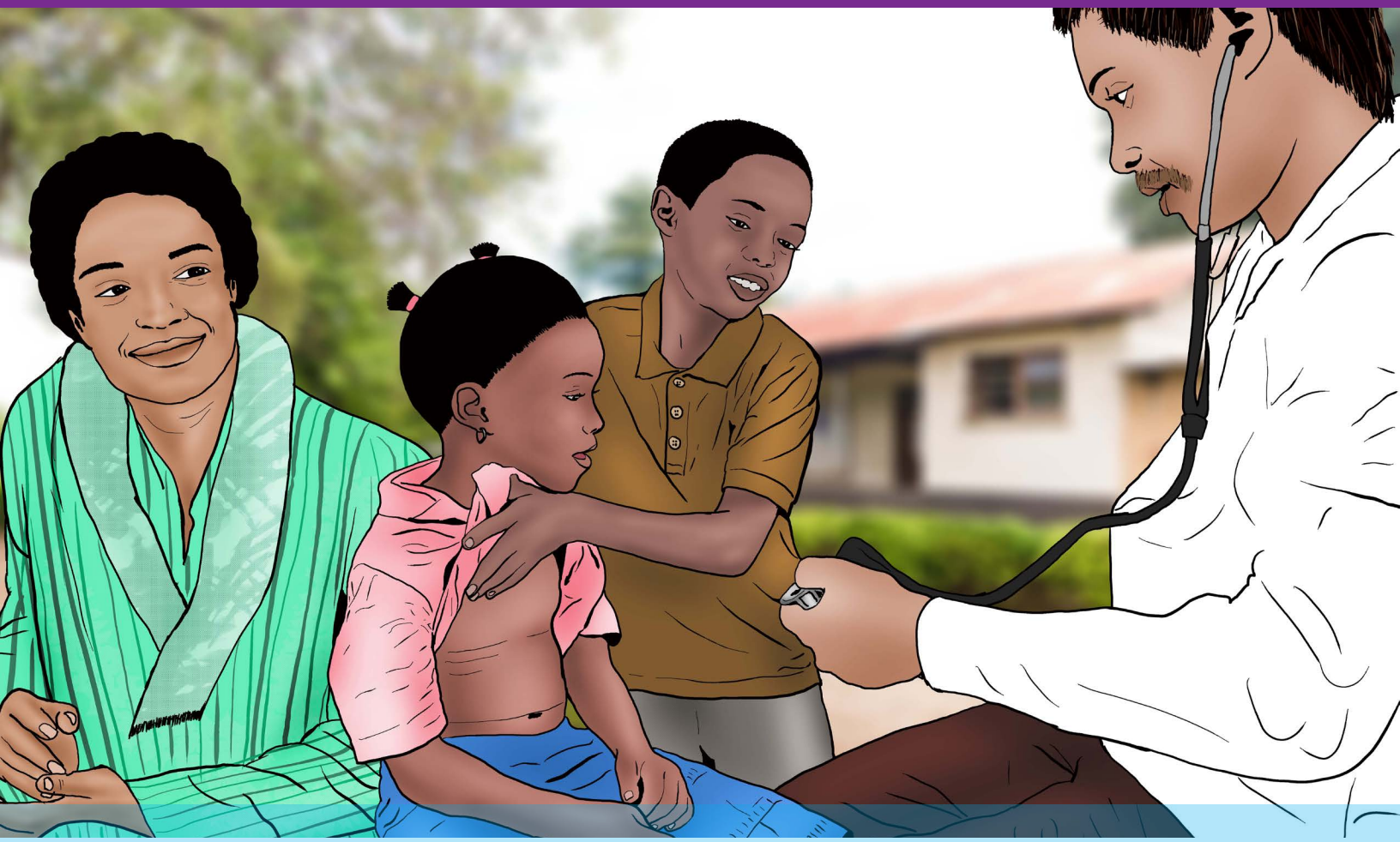
Rees CA, Sirna SJ, Manji HK, Kisenge R, Manji KP. Authorship equity guidelines in global health journals. BMJ Glob Health. 2022;7(10):e010421. doi:10.1136/bmjgh-2022-010421

Summary: There is significant under-representation of authors from LMICs in studies conducted in LMICs, and while global health journals have general authorship guidelines, few include specific language about local authorship. Journals should create guidelines promoting equitable authorship practices.

Smith E, Hunt M, Master Z. Authorship ethics in global health research partnerships between researchers from low or middle income countries and high income countries. BMC Medical Ethics. 2014;15(1):42. doi:10.1186/1472-6939-15-42

Summary: This paper highlights four authorship issues in global health research: 1) exclusion of non-English speaking researchers, 2) unfair practices resulting from power dynamics between LMIC and HIC researchers, 3) editorial bias favoring well-renowned Western researchers, 4) and conflict resulting from diverse cultural practices. Authors suggest solutions.

CASE 2: Scope of Practice and Moral Distress



LEARNING OBJECTIVES

- **Identify points of contention around flexibility/adaptability and moral distress, and understand the two sides of the story in this case study**
- **Explore how you would respond in situations wherein you and your coworkers have different strategies for research or patient care**
- **Reflect on how clinical researchers' roles and responsibilities may in differ in various cultural and resources settings, and why these differences came to be**

JATIE is a postdoctoral fellow from the US who is working in Kenya as a researcher at a university hospital. His research focuses on HIV associated cancer, outcomes of patients treated for lymphoma, and the cost-effectiveness of lymphoma treatment globally. But he is also an experienced adult oncologist, trained in the US and accustomed to cutting-edge therapies, such as targeted immunotherapy. Working in a cancer clinic abroad has been a great experience. At times, he feels like the only experienced medical oncologist practicing at the hospital.

There is another post-doctoral fellow, Ayesha, who is local, and with whom Jatie has developed a friendship. At one point, Jatie mentioned to Ayesha that he has found the lack of available treatments frustrating. Jatie notes that he is aware of cancer treatments that are expensive and very effective; however, due to limited supply of drugs, he is forced to choose who gets the drug. He mentions it has also been challenging due to a lack of local treatment guidelines:

> ***It would be nice if the Ministry of Health gave guidance on what happens when they have purchased the drugs and there's only a limited supply? Right now it's just kind of like first come, first serve… then when it runs out, it runs out. So it might be nice if they kind of gave some guidance about what situations we should, or should not use it.***

Ayesha is a bit surprised. Locally, part of training is helping identify patients who would most benefit from certain treatments. But Jatie is still uncomfortable. Jatie mentions his local mentor, Abdul, asked him to help with the clinical decisions and seems to assume Jatie knows how to triage. But Jatie has not brought it up directly, and he feels like triage decisions are outside the scope of both his training and his research. He is there to do research, after all, not triage patients.

DISCUSSION QUESTIONS

1. In this case, Jatie feels uncomfortable making triage decisions, but Ayesha does not. What do you think are the causes of this - individually for Jatie, Ayesha, and Abdul, as well as from the standpoint of Jatie's training program? Be sure to address both individual- and institution-level issues.

ETHICS ACTIVITY

Pair up with your mentor or a peer. One of you should play the role of Abdul, and the other, Jatie. Together, decide on a task that would be outside your scope of practice/training if you were asked to do it abroad or in an unfamiliar setting. The person playing the role of Abdul should approach Jatie and say, "Jatie, I would like you to help by... [insert the task you decided upon here]." Whoever is playing Jatie should practice how to respond to a request that is outside the scope of practice/training.

THE CASE CONTINUES

Jatie knows how a patient would be treated in the US (where he trained), but here people sometimes do not get treatment at all. Jatie explains that decision-making for their clinical team heats up when resources are not available and in other circumstances when novel, expensive therapies are available but in very limited supply. Jatie feels frustrated. Some of these issues are outside the research project altogether, but he still feels that as a physician he has an obligation to help people - for example, if a research participant needs care for high blood pressure. To address the treatment allocation problem, Jatie works with Ayesha on an observational study that could use research funding to pay for expensive therapies. They have also developed an ethical framework that guides treatment allocation:

> ***But where are we struggling? It is when more expensive novel therapies that can cure patients are available. These drugs increase the chances of cure by about 20% for patients with certain types of lymphoma, and are also used to treat a lot of what we call low grade lymphoma. But it does not really cure others patients with chronic cancer. So the decision by our team has been that whenever possible, whenever there is a stock of the drug, we should give it to patients who have curable cancers.***

DISCUSSION QUESTIONS

1. As this second part of the case reveals, Jatie is experiencing some form of "moral distress" - a sense of knowing the right thing to do but being unable to do it. These patients could be treated, but resource limitations prevent Jatie from doing so. Have you experienced this kind of distress before? What was the root cause of moral distress? Think of one concrete step that you, your mentors, and your training program could each take to respond to it.
2. How best can Jatie balance his obligations as a physician and a researcher? In the ethics literature, questions arise about "ancillary care" - care that people in research may need but that goes beyond the scientific needs of a study. Does Jatie have obligations to care for people outside the study, such as regarding their hypertension? Or, how would he know?
3. Reflect for a moment on how the global health funding structure does - or does not - support people like Jatie when it comes to these care needs. What could be changed?

TAKE-AWAY!

Think of one lesson from this case that you will take with you in your current and future career.

FURTHER READING

Harrison JD, Logar T, Le P, Glass M. What Are the Ethical Issues Facing Global-Health Trainees Working Overseas? A Multi-Professional Qualitative Study. Healthcare (Basel). 2016;4(3):43. **doi:10.3390/healthcare4030043**

Summary: This qualitative study explores ethical dilemmas faced by trainees during placements in LMICs, identifying four themes: 1) cultural differences, 2) professional issues, 3) limited resources, and 4) personal moral development.

Hunt M, Schwartz L, Fraser V. "How Far Do You Go and Where Are the Issues Surrounding That?" Dilemmas at the Boundaries of Clinical Competency in Humanitarian Health Work. Prehospital and disaster medicine. 2013;28:1-7. **doi:10.1017/S1049023X13008698**

Summary: Humanitarian health professionals face unique ethical challenges. Addressing these dilemmas requires practical wisdom, not just adherence to ethical codes; authors propose questions to guide clinicians in assessing unfolding situations and debriefing on past experiences, and to support them in providing ethical care and services when in moral distress.

Kapumba BM, Desmond N, Seeley J. A chronological discourse analysis of ancillary care provision in guidance documents for research conduct in the global south. BMC Medical Ethics. 2022;23(1):51. **doi:10.1186/s12910-022-00789-6**

Summary: The lack of clarity and consistency explaining researchers' responsibility for ancillary care has resulted in an under-representation of ancillary care in local ethical guidelines and regulations, leaving ethics committees without clear directives for regulating these services.

Rushton CH. Defining and addressing moral distress: tools for critical care nursing leaders. AACN Adv Crit Care. 2006;17(2):161-168.

Summary: Nurse clinicians facing moral distress can utilize the AACN's Model to Rise Above Moral Distress, encompassing four steps (ask, affirm, assess, and act) and implementing 11 steps to foster an ethical practice environment and address moral challenges.

Manabe YC, Jacob ST, Thomas D, et a. Resurrecting the triple threat: academic social responsibility in the context of global health research. Clin Infect Dis. 2009;48(10):1420-2. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2752893/**.

Summary: Due to the HIV pandemic, academic physicians engaged in infectious disease research are increasingly working in LMICs, presenting an opportunity for institutions and funders to have a lasting impact on local health systems by training local health workers and building capacity through clinical involvement, teaching, and mentorship.

CASE 3: Cultural Differences, Informed Consent, and Power Dynamics in Partnerships

LEARNING OBJECTIVES

- **Identify sources of communication-breakdown between researchers from different cultural and resource settings, and what you might do to build trust and improve communication as a fellow**
- **Outline individual and structural factors that impact research priority-setting in global health**
- **Examine the role that privilege plays in relationship dynamics between researchers in different cultural and resource settings, and how structural factors in either setting could perpetuate these dynamics**

JASMINE is an American postdoctoral student working on a field project in Brazil related to perinatal nutrition. Her team consists of a local mentor from Brazil, her US-based mentor at her home institution, and Maria, a research assistant in Brazil who desires to get her PhD one day.

A few months into her project, Jasmine is talking with Maria, who confides in her that the local team has made some decisions without the input or approval of US-based investigators. For example, although the protocol asked for consents to be done in the research office, the field teams found this infeasible, and started doing consents at people's homes in the field. The Brazilian team was reluctant to tell the US-based investigators directly about this change; they felt that it was a minor change in procedure, not a change in protocol. Jasmine feels caught in the middle, wondering how the ethics principles she had learned applied here in Brazil:

> *After a while…they started earning my trust. They would be honest with me, with the decisions that they were making, and what they were (and were not) telling the US team… American people are more blunt…here [being blunt] would be considered rude or just something that you would not do... [During training] it was all really clear cut…you got into the field, you were not sure how to apply what you'd been taught to fit the environment.*

DISCUSSION QUESTIONS

1. In this situation, it is unclear whether the change in the consent procedure was significant, but there seemed to be a breakdown in communication. Why do you think the team might have felt somewhat reluctant to bring the issue up "directly" to the US team. If so, is there something you think could be done to prevent this from happening?
2. With what she learned, Jasmine expresses being caught in the middle between the US-based team and the local one. How would you manage this if you were Jasmine?
3. Jasmine notes some potential differences in culture that contributed to this issue. Can you think of another situation where differences in culture might make it harder to discuss an ethics issue?

THE CASE CONTINUES

Later in the project, Jasmine and Maria work on some preliminary data analyses, and together they decide to propose a conference abstract with Maria as first author. But they run into a couple issues. One is that Jasmine has difficulty in finding time on Diego's calendar to get feedback. She knows that he is very busy; he is the local contact for what seems like dozens of projects. Jasmine has at times wondered if she is an excess burden on the local site. Meanwhile, her US based mentor – who has not been in-country for some time due to other obligations - opposes getting the study results out too quickly, stating, "I do not think you can submit this. We do not want to put this kind of work out there before we have all our results." He also questions whether Maria has done enough to merit first authorship. Jasmine wonders:

> *I want to do the work, but also, am I creating more of a burden on the site by being here? Is it okay for me to be frustrated that the site PI never meets with me? It is not ethical for me to submit without approval, but I also do not have the ability to continue waiting… Everybody, the people who are leaders there were wearing 10,000 hats right there, chair of their department…PI on the ground… mentoring their own students…so it is like singular people [i.e., one person who seems to have many, overlapping responsibilities].*

DISCUSSION QUESTIONS

1. In this case, there seem to be different perspectives on how "ready" data are for presentation. Why would this be? Try to identify structural factors that contribute to this (e.g., about the funding environment, global health research priorities, career development, etc.).
2. Jasmine seems to desire mentorship from Diego, but feels like she is a burden on the mentor or team in Brazil. Why do you think this might be? Can you think of a concrete way individuals, institutional partners, or others could alleviate the stress on these "singular" people?

THE CASE CONTINUES

As Jasmine's project concluded, she ended up presenting an abstract at a local conference. Jasmine was first author, and Maria was second. And, Jasmine was given an award for the research. She felt conflicted about it, which caused her to reflect upon the way both she and Maria were treated during her time in Brazil. As Jasmine explains:

> ***I remember being, like, appalled that they would give [the award] to this American colleague…I think what I noticed most was the privilege from just the community members I was afforded that maybe other [locals] would not be afforded…it felt like unearned privilege… like white guilt and placing the burden on the in country mentor to sort of alleviate me of all these feelings.***

DISCUSSION QUESTIONS

1. What do you think explains Jasmine's feelings that she received differential treatment than Maria? (HINT: Think of not only the interpersonal interactions, but also the structural factors, such as Jasmine's pressure to get her work out there, program issues, and power structures in global health.) Can you think of a few ways to help avoid this in the future?

ETHICS ACTIVITY

Situations like this sometimes motivate people to consider the idea of "bidirectional exchange." Read the following article:

Arora, G., Russ, C., Batra, M., Butteris, S.M., Watts, J. and Pitt, M.B. Bidirectional exchange in global health: moving toward true global health partnership. The American Journal of Tropical Medicine and Hygiene 2017;97(1):6. https://doi.org/10.4269%2Fajtmh.16-0982

Summary: There is a growing call for parity and bidirectional exchanges to promote equitable educational experiences for both LMIC and HIC researchers. This article emphasizes the need for academic health centers in the US to host and provide "meaningful global health experiences" for learners from LMIC partner institutions, outlining benefits, challenges, and potential solutions.

With your mentor or a peer, discuss ways to overcome the "challenges" to bidirectional exchange.

TAKE-AWAY!

Think of one lesson from this case that you will take with you in your current and future career.

FURTHER READING

Hamer DH, Hansoti B, Prabhakaran D, et al. Global Health Research Mentoring Competencies for Individuals and Institutions in Low- and Middle-Income Countries. Am J Trop Med Hyg. 2019;100(1_Suppl):15-19. **doi:10.4269/ajtmh.18-0558**

Summary: Mentoring plays a crucial role in global health research, particularly in LMICs, and can be strengthened by defining key competencies for effective mentoring, providing training for local research mentors, and supporting institutional capacity building. This article identifies nine core global health research mentoring competencies.

CASE 4: Authorship and Where Credit is Due

LEARNING OBJECTIVES

- **Compare the local surgeon and visiting fellows' perspectives on "valid" sources of knowledge/scientific evidence, data ownership, and credit for work/ideas, and reflect on how individual, institutional, and structural factors may have developed or nurtured these perspectives**
- **Outline the ways in which mentorship affects global health researchers' career trajectories, and how the availability of resources may facilitate or hinder professional growth**
- **Discuss potential roots of bias against LMIC authors in academic publishing, and envision how you might reduce this bias as a hypothetical editor**

CHIFUNDO is a physician working at a public hospital in Togo. He has been working in the cardiac unit for more than 5 years and he is interested in research related to cardiovascular disease prevention. During his practice, he developed and implemented a blood pressure screening clinic which has served over 1000 patients. This initiative has been scaled up in other hospitals across Togo. While working in the clinic, Jimmy – a postdoctoral research fellow from the US who is trained in cardiac epidemiology – came to work with Chifundo as part of a one-year training program in global health.

At one point, based on his prior experience and training, Chifundo mentioned a possible diagnostic association to Jimmy. In short, Chifundo had learned from a local mentor that a specific biomarker is highly associated with future risk of certain cardiovascular diseases. However, the association had not been formally studied or published. When Chifundo told Jimmy about this, Jimmy seemed skeptical. Chifundo relates:

> ***So, I graduated and started working at a rural place, and [when this HIC] expert came through, I told him about the association. As far as I can remember my teacher had told me about that…[but] the expert said, 'No it can not be.'***

Responding to Jimmy's skepticism, Chifundo recommended that they study the issue formally. And even within that local rural set up, they found the association held in more than 90% of patients. The findings were published, but Chifundo was not included on the publication. As he recalled:

> ***There was a small publication that was done at that time and I remember afterwards that I was not interested in the research. But it could have been, [if] I was mentored in such a way, I could have preferred to be included.… but [sometimes] you are left out in the cold.***

DISCUSSION QUESTIONS

With a mentor or one (or more) of your peers, discuss the following questions.

1. This case involves an experienced local surgeon and a visiting postdoctoral fellow. It seems these two have different perspectives on the value of different forms of scientific knowledge or scientific contribution. Take a few moments and reflect on what Chifundo and Jimmy might be feeling and thinking about the following issues.

Issue	Chifundo's perspective	Jimmy's perspective
The role of practical or experiential knowledge in scientific research		
Ownership over ideas or data, including the conception of the project		

Before leaving this section, take a moment and think about why Chifundo and Jimmy might have these different perspectives. What structures, formal (such as funding) or informal (such as institutional culture) might contribute to these different perspectives?

2. In the final quote, Chifundo expresses feeling left out, and thinks mentoring could have helped him understand the value of participating in the research and even helping him do so. Can you think of reasons - individual, institutional, or others - why finding mentorship might be more challenging for someone like Chifundo, compared to Jimmy?

   In follow up, what concrete steps could individual mentors, other trainees, and training programs take to help mentor someone like Chifundo?

THE CASE CONTINUES

Chifundo felt exploited. On the one hand, he was given financial remuneration for some of the time he was working with Jimmy. But on the other, he was left off the publication. He felt like there was an assumption being made that financial support was his sole motivation and that it was sufficient for his engagement. And he begins to wonder if parts of global health research need more comprehensive approaches to "fairness."

> ***Frankly speaking…a good number of people come up with monetary incentives rather than mentorship. They give you money as an incentive, so you do not appear on research work that is undertaken. I believe if people are empowered, they can compete favorably.***

DISCUSSION QUESTIONS

1. With a mentor or a peer, discuss different ways that people can receive "credit" for what they have done in research. What assumptions do people make about credit, and why? Do you think there are cultural differences in how people view forms of credit?

THE CASE CONTINUES

Later, Chifundo decides to discuss the authorship issue with someone else in the clinic where he works. As they were talking, his colleague mentions that, even if he had been an author on the paper, it can still be hard to get published. She tells Chifundo about the challenges of authorship – especially lead authors – for people from LMICs and for people who speak languages other than English. She relates a story of where a particularly negative paper review seemed directed at the LMIC lead author, just because it was an LMIC author :

> ***And you know the first [time we had a review like this]…I just thought, 'Well, this is just an anomaly. This is a poor reviewer.' But when it happened nearly every single time we submitted with the [LMIC] first author, I mean…it is kind of incredible that bias that comes through in the reviews, and also that editors allow those types to actually make it to the authors…When I have had a US [person] as first author we've never gotten any review like that.***

DISCUSSION QUESTIONS

1. In this scenario, a mentor references potential biases in publication. What do you think are the root causes of publication bias against LMIC authors?
2. Imagine yourself to be a journal editor. What concrete steps do you think could be taken during the (a) submission, (b) review, and (c) publication process to minimize this bias?

TAKE-AWAY!

Think of one lesson from this case that you will take with you in your current and future career.

FURTHER READING

Ghani M, Hurrell R, Verceles AC, McCurdy MT, Papali A. Geographic, Subject, and Authorship Trends among LMIC-based Scientific Publications in High-impact Global Health and General Medicine Journals: A 30-Month Bibliometric Analysis. J Epidemiol Glob Health. 2021;11(1):92-97. doi:10.2991/jegh.k.200325.001

Summary: This analysis of articles published in general medicine/global health journals (2014-2016) reveals that Africa, with a quarter of the LMIC population, accounted for almost half of the publications, and corresponding authors from LMIC institutions were present in a quarter of the articles. Most publications did not include local authors, and non-HIV infectious diseases were the primary subject areas, highlighting a need to address gaps in LMIC authorship representation and subject diversity.

Harris M, Marti J, Watt H, Bhatti Y, Macinko J, Darzi AW. Explicit Bias Toward High-Income-Country Research: A Randomized, Blinded, Crossover Experiment Of English Clinicians. Health Aff (Millwood). 2017;36(11):1997-2004. doi:10.1377/hlthaff.2017.0773

Summary: This experiment found that changing the source of a research abstract from an LMIC to an HIC significantly improved how it was perceived, with higher ratings of relevance and recommendation to a peer, highlighting how unconscious bias could impact interpretation of LMIC research and its implications for equitable knowledge dissemination.

Modlin CE, Deng Q, Benkeser D, et al. Authorship trends in infectious diseases society of America affiliated journal articles conducted in low-income countries, 1998-2018. PLOS Glob Public Health. 2022;2(6):e0000275. doi:10.1371/journal.pgph.0000275

Summary: While there is a growing amount of infectious disease research conducted in LICs, there is an exclusion of LIC-affiliated investigators as lead authors, with only 50% of publications having a LIC-affiliated first/last author and a decreasing proportion of articles with LIC-affiliated lead authors over time.

Rodríguez DC, Jessani NS, Zunt J, et al. Experiential Learning and Mentorship in Global Health Leadership Programs: Capturing Lessons from Across the Globe. Ann Glob Health. 2021;87(1):61. doi:10.5334/aogh.3194

Summary: Experiential learning and mentorship are crucial components of global health leadership programs, providing practical training and support for the next generation of leaders. Showcased programs highlight the importance of "inter-professional training, mixed-learning approaches," mentorship, capacity building, and professional network development.

Smith E, Hunt M, Master Z. Authorship ethics in global health research partnerships between researchers from low or middle income countries and high income countries. BMC Med Ethics. 2014;15:42. doi:10.1186/1472-6939-15-42

Summary: This paper highlights four authorship issues in global health research: 1) exclusion of non-English speaking researchers, 2) unfair practices resulting from power dynamics between LMIC and HIC researchers, 3) editorial bias favoring well-renowned Western researchers, 4) and conflict resulting from diverse cultural practices. Authors suggest solutions.

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Abimbola S, Pai M. Will global health survive its decolonisation? The Lancet. 2020;396(10263):1627-1628. **doi:10.1016/S0140-6736(20)32417-X**

Abouzeid M, Muthanna A, Nuwayhid I, et al. Barriers to sustainable health research leadership in the Global South: Time for a Grand Bargain on localization of research leadership? Health Res Policy Syst. 2022;20:136. **doi:10.1186/s12961-022-00910-6**

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FACILITATOR NOTES

Cases are intended to be read and reflected on in groups. Ideally, fellows should read cases in small groups and conduct activities together. They work better in person, but can be done remotely by splitting fellows into breakout rooms. It is recommended that they read through the full case and suggested readings before delving into activities.

CASE 1. Access and Ownership of Research Data

Global health research (often led by individuals in institutions in HICs) has a history of being exploitative of research participants, researchers, and research institutions in LMICs. Stakeholders in LMICs are not always included in the conception, implementation, and/or dissemination of research in their settings. This case should spur discussions about that history and the ways in which these dynamics exist today. After reading and reflecting on this case, fellows should be able to contemplate their own role in perpetuating or changing these dynamics (and the ways in which they have or do not have leverage to do so). Fellows should discuss the benefits versus risks of global health research and identify the nuances of "working themselves out of a job."

CASE 2. Scope of Practice and Moral Distress

Visiting researchers in LMICs often wear multiple hats and hold more responsibility than they were formally trained to hold. This can require compromise and flexibility, as well as an ability to delineate what fellows have the power to do versus what is beyond their control. This case study should spur conversations about this distinction, and about how structural factors in their research placement setting may push them out of their comfort zone. This can serve as a point of reflection for their own positionality and background. Fellows should think about the assumptions the characters have made in this case study, and how these assumptions and their respective outcomes could serve as a learning opportunity for what to do/not to do when workplace conflict arises. It is especially important that fellows reflect on the power dynamics between visiting researchers and local staff, and how that might play out in workplace conflict.

CASE 3. Cultural Differences, Informed Consent, and Power Dynamics in Partnerships

Cultural values can determine priorities in global health research. In this case study, we want fellows to reflect on what those values are in their home institution(s) (where they trained/have worked previously) versus their visiting institution. Different values, as well as power dynamics between visiting scholars and local staff may compromise communication and potentially impact the quality of research. Fellows should reflect on what could have been done to improve communication for the characters in this case study, and how they plan to take these lessons and apply them to their fellowship.

In the second part of the case, Jasmine feels conflicted about her need for increased time/effort from Javier, as well as receiving an award for work she completed with Maria. Fellows should think about why Diego has not been able/willing to provide Jasmine with the level of mentorship she seeks (e.g. lack of protected time for mentorship, conflicting priorities, different institutional culture around roles and mentorship, etc.). They should also reflect on differential treatment and if they have had similar experiences. Potential explanations for the differential treatment in this case are: valuing US-voices over local voices, a difference in the way the work was presented by Jasmine versus Maria, etc.. They should discuss how "white guilt" might negatively or positively affect their work and relationships at their visiting institution.

CASE 4. Authorship and Credit Where Credit is Due

Publication and authorship are not everybody's priority–fellows should reflect on the nuances of why Chifundo might have felt left out or exploited when he was excluded from the publication (e.g. feeling hurt by Jimmy's initial rejection of Chifundo's knowledge, a sense of injustice that some forms of knowledge are honored over others, heightened sensitivity to dynamics that existed prior between HIC and LMIC scholars/clinicians, etc.).

Additionally, global health researchers have historically valued certain types of evidence (e.g. results of randomized trials) over others (e.g. qualitative or anecdotal evidence). Because of limitations in resources or capacity in some settings, more expensive or time-intensive research was or is not always possible. By the standards of some researchers trained in high-resource institutions, a lack of experimental evidence indicates no evidence. Fellows should reflect on whether/why they might have this perception, and whether there are other ways to think about knowledge and evidence. Once they have done that, they should discuss who should receive credit for this knowledge and evidence, whether anecdotal or experimental.

WE VALUE YOUR FEEDBACK!

Please scan the QR code below or click the link to fill out a short survey about these cases.

https://unc.az1.qualtrics.com/jfe/form/SV_bD6d6hgvnFTlPY

Your answers are anonymous unless you choose to share your contact information for us to follow up with you!