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Beyond high-level recommendations and rule books: doing the 'hard work' of global health research – lessons and recommendations from an interdisciplinary global partnership

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INTRODUCTION

Although most global health research strives towards fostering equal partnerships—which promote mutual input, respect and value equally shared contributions at all stages—power differentials and structural inequalities remain.[1–5] There have been increasing calls to 'decolonise' global health research by adopting approaches which favours equity, justice and challenge colonial and historical assumptions.[2 5–7] However, these calls tend to either highlight higher systemic failures or often tend to offer broad 'how to' rules to researchers wishing to adopt more 'decolonised' approaches in their work.[1 2 8–10] Few papers share practical lessons embedded in the day-to-day experience of 'doing the hard work' of global health research together, with some notable exceptions.[11–13]

In this commentary, we draw on our own Global South/Global North team's experience of working together on an exploratory project in Kenya and Malawi (the Fuel to Pot project-F2P). The F2P project used photovoice (where community residents took pictures of the issues that mattered to them and then alongside the researchers sorted and analysed the photos and their meaning[14] and walking interview (where the researchers walked along with the community residents as they procured their fuels then cooked and interviewed them while also measuring air pollution). These participatory methodologies enabled a deeper understanding of informal settlements residents' experiences and priorities regarding the use of solid fuels for cooking In this article, we are using the terms Global North and South, which are accepted terms within the field, rather than high-income/low-income countries as we feel the World Bank typology reinforces economic hierarchies and the idea that a low income country is also low resource and low capacity. Although we acknowledge that there is no ideal nomenclature.[15]

In this commentary, we draw on our collaborative experiences of 'doing research' together for several years on the F2P study and we also draw on recent frameworks and guidance,[1 2 4 7] to explore our own challenges, share lessons learnt at key stages of the research process and make pragmatic recommendations. Our commentary reflects both our Global South and North voices and is addressed to both audiences.

SUMMARY BOX

⇒ Global health research collaborations and partnerships take time to establish and must be supported adequately.
⇒ Bureaucratic contracting and procurement processes delay research and must be simplified.
⇒ Contingencies and funding must be made available when the unforeseen in global research happens (eg, pandemics, disasters, climate crises and conflicts).
⇒ We must balance the need for essential travel in this type of research with the need to limit environmental impact.

STAGE 1: SUPPORTING THE DEVELOPMENT OF RESEARCH IDEAS AND ESTABLISHING PARTNERSHIPS

Funding for global health research often originates in the Global North, which is where priorities and modalities for governance are also set. This has a knock-on effect on all aspects of the research process.[2 4 7 12] In the development of the F2P project, there were no sufficient funds to bring international partners together face-to-face to discuss ideas at the start, therefore, an online workshop was organised with researchers from various disciplines in the UK, Kenya and Malawi, and this was made feasible by pre-existing links. We continued our discussions both online and through a meeting held in Malawi with some team members, which was enabled by a very small seed funding grant from the UK institution. We continued to codevelop a research proposal together online, which was then submitted to a UK funder. However, this process alone took over a year.

Lesson learnt? Developing partnerships based on mutual respect and trust takes time, developing research proposals collaboratively also takes time and space. Therefore, we encourage more funding bodies and academic institutions to offer small seed grants and funded places on workshops and conferences to bring Global South and North together researchers to develop ideas and proposals at the preapplication stage, thus enabling more 'real' collaborations to develop.

STAGE 2: OVERCOMING OBSTACLES AT THE START OF A STUDY (POST AWARD)

Defining roles and accountability mechanisms as well as adequate modes of communication from the start of a research project are seen as essential to highly functional research partnerships.[4 16] However, the processes of setting up contracts and undertaking due diligence (generally initiated from the Global North if that is where funds originate) can feel unnecessarily complex and can impede the 'take-off' of a project significantly. Acquiring the necessary ethical approvals in all countries is vital in any global health project to avoid ethics dumping and other unethical research practices.[1 2] However, current ethical clearance processes can be complex, decontextualised and lengthy and can sometimes further delay the start of a research project.[17] Even once a project is funded, and cleared, getting the funds to flow smoothly to partners in the Global South can be problematic and the timing of payments does not always meet expectations or needs on the ground where the research is undertaken.[18] The purchasing of specialist equipment necessary for some research can also be logistically very difficult.[18] For our project, we experienced difficulties in purchasing specialist air quality monitoring equipment in country, dealt with high rates of import taxation on goods we shipped to Global South partners and also faced the actual loss of shipped equipment. Although these problems may not be within the purview of Global South or North partners to solve, we acknowledge them as common to most of us doing this type of research.

Notwithstanding such obstacles, in any global research project, roles and responsibilities have to be negotiated and equally distributed at the start, and all must learn new ways of being and researching together, which takes time.[2 4 12] In this respect, our F2P project taught us that even though online communications have improved markedly over the past decade—with video conferencing (Zoom, Teams and WhatsApp)—they still present major challenges in countries where internet connections are very poor and power cuts are relatively frequent.

Lesson learnt? Bureaucratic contracting and administrative processes, and burdensome procurement are not specific to global health projects but they introduce significant delays in 'starting' research and could be simplified.[17] Such delays can also have a 'chilling' effect on building trust and managing expectations at the start of any collaboration—particularly where partners are far away, e-connections are poor and people are still learning to work together—ultimately, this may be detrimental to maintaining long-term international partnerships. Specific resources to improve communications must be made available by funders, particularly in smaller projects (eg, internet dongles, broadband and data costs)

STAGE 3: DOING THE 'HARD WORK' OF GLOBAL HEALTH RESEARCH (DURING THE PROJECT LIFE CYCLE)

'Doing' mutually respectful research together in global health across continents is 'hard work'. Furthermore, at any point in the research cycle, occurrences of conflicts, weather disturbances and climate disasters, civil unrest, changes in governments, health crises (eg, ebola, Zika and mpox), and pandemics can also happen. Although by nature unpredictable, these events cannot only slow down or even halt the research process altogether, they also crucially place undue burdens, risks and stresses on local staff in the Global South, where the fieldwork often takes place. Conversely for Global North partners, stresses can also arise from cuts in funding, from ongoing losses of connection with partners, or persistent worries over colleagues' welfare. In our project, we experienced the COVID-19 pandemic as did many others, as well as some funding early on (owing to the 2021 reductions in the UK budget for Official Development Assistance. However, it must be highlighted and lauded that, in our case, the UK funder prioritised protecting Global South partners budgets which did not incur a loss. Although these were unavoidable circumstances, they made the progress of 'doing' this research much more challenging for us as Team.

Lesson learnt? In this type of research, mechanisms should be put in place by leading institutions and funders so that potential risks can be identified early, and so that local researchers in the Global South can be protected. Funding bodies could make emergency research funds

and costed extensions available when unforeseen events take place which considerably delay the research progress.

STAGE 4: PRIORITISING RESEARCH CAPACITY STRENGTHENING

Research capacity strengthening (RCS) at all levels is now seen as a vital component of equitable research partnerships,[2 4 7] and seen as a reciprocal activity whose goal is one of mutual benefit and development.[10] In the F2P project, Team members—both from the Global North and South—codesigned and codelivered a programme of training and knowledge exchange over the course of the study. We used reflective diaries to assess our progress and improve our processes. We also made real efforts—within tight budgets—to bring team members together face to face, while prioritising South-to-South exchange and reverse innovation thinking. This significantly strengthened mutual research capacity and helped build lasting relationships based on respect.[2] However, our experience is that travel visas are onerous and costly for Global South researchers, which makes face to face RCS difficult; in-person visits remain expensive and their impact on climate change cannot be overlooked.

Lesson learnt? RCS programmes must acknowledge the capacities, assets and needs of both Global South and North researchers. We urge funding bodies to continue to look kindly and flexibly at ways to allow teams to budget for essential travel for visits focused particularly on reciprocal RCS while continuing to be mindful of the need to minimise carbon footprints, in the context of the climate emergency. New working practices that minimise carbon-intensive travel should be considered at every stage of the project.[19]

STAGE 5: MAINTAINING PARTNERSHIPS AFTER A PROJECT ENDS

One of the aspects of global health research least discussed is that of the final stage. While some have highlighted the importance of sustaining partnerships beyond the funding cycle,[4 12] and others of the necessity to encourage continued equitable authorship,[7] the reality may be quite different. Recently, projects which have experienced the delays described above, have been granted no-cost extensions from funders to complete their work. Those are welcomed and appreciated as they afford more time to complete the work. However they also effectively may mean that the vital dissemination phase of global health projects become more difficult and more stretched.[18] Too often, partnership continuation very much depends on the 'good will' and motivation of the researchers involved (some of whom are in relatively more secure funded posts, and others not). Beyond the life of a project, partners must continue to navigate institutional modalities around data access and sharing.[20] Those heavily depend on whether collaborating institutions continue to ensure sustained shared ownership and equitable access to the data after the projects end.

Lesson learnt? In the current context, more time and extra funding need to be awarded to projects to devote to the latter stage of the research around dissemination and impact. This could be done by highlighting this to funders and applicants from the application stage and taking a more end-to-end approach to the funding cycle, recognising that not all dissemination and impact opportunities will be known at the start but may develop throughout). We welcome warmly, for instance, the attempt by some funders to offer follow-on 'impact and dissemination' funding to facilitate further engagement including with communities who were involved in the research throughout as well as policy-makers and other coalitions. Funding could also be made available for journal fee waivers and conference attendance costs (where the opportunity for those not known at the start of a research project). In our case, we luckily benefited from further funds from the lead university which enabled us to conduct visualisation and discussion events in Kenya and Malawi after the end of the project.[21]

CONCLUSION

The desire to improve the health and well-being of all populations is what drives the global health research community. International research collaborations are key in this effort. However, the practicalities of 'doing the hard work' of global health research, which decolonised approaches and equal partnership 'rule books' advocate, remain substantial, especially for small projects with limited funding and time frames. We encourage academic institutions and research funding bodies to give our pragmatic recommendations some consideration, across all stages of the research cycle.

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REFERENCES

1 Keynejad RC, Deraz O, Ingenhoff R, *et al*. Decoloniality in global health research: ten tasks for early career researchers. *BMJ Glob Health* 2023;8:e014298.
2 Haelewaters D, Hofmann TA, Romero-Olivares AL. Ten simple rules for Global North researchers to stop perpetuating helicopter research in the Global South. *PLoS Comput Biol* 2021;17:e1009277.
3 Shiffman J. Global Health as a Field of Power Relations: A Response to Recent Commentaries. *Int J Health Policy Manag* 2015;4:497–9.
4 Voller S, Schellenberg J, Chi P, *et al*. What makes working together work? A scoping review of the guidance on North-South research partnerships. *Health Policy Plan* 2022;37:523–34.
5 Khan M, Abimbola S, Aloudat T, *et al*. Decolonising global health in 2021: a roadmap to move from rhetoric to reform. *BMJ Glob Health* 2021;6:e005604.
6 Bhakuni H, Abimbola S. Epistemic injustice in academic global health. *Lancet Glob Health* 2021;9:e1465–70.
7 Morton B, Vercueil A, Masekela R, *et al*. Consensus statement on measures to promote equitable authorship in the publication of research from international partnerships. *Anaesthesia* 2022;77:264–76.
8 Schriger SH, Binagwaho A, Keetile M, *et al*. Hierarchy of qualities in global health partnerships: a path towards equity and sustainability. *BMJ Glob Health* 2021;6:e007132.
9 Mutapi F, Banda G, Woolhouse M. What does equitable global health research and delivery look like? Tackling Infections to Benefit Africa (TIBA) partnership as a case study. *BMJ Glob Health* 2023;8:e011028.
10 Monette EM, McHugh D, Smith MJ, *et al*. Informing 'good' global health research partnerships: A scoping review of guiding principles. *Glob Health Action* 2021;14:1892308.
11 Philipo GS, Nagraj S, Bokhary ZM, *et al*. Lessons from developing, implementing and sustaining a participatory partnership for children's surgical care in Tanzania. *BMJ Glob Health* 2020;5:e002118.
12 Voller S, Chitalu C-CM, Nyondo-Mipando AL, *et al*. 'We should be at the table together from the beginning': perspectives on partnership from stakeholders at four research institutions in sub-Saharan Africa. *Int J Equity Health* 2022;21:111.
13 Yusuf ZK, Mademilov M, Mirzalieva G, *et al*. Qualitative research capacity building: Reflections from a UK-Kyrgyz Republic global partnership. *J Glob Health* 2021;11:03127.
14 Uny I, Chasima T, Caes L, *et al*. n.d. Exploring the use of solid fuels for cooking in informal settlements through photovoice: the Fuel to Pot study in Malawi and Kenya (Under Rev). *PLoS One*.
15 Khan T, Abimbola S, Kyobutungi C, *et al*. How we classify countries and people-and why it matters. *BMJ Glob Health* 2022;7:e009704.
16 Pratt B. What constitutes *fair* shared decision-making in global health research collaborations? . *Bioethics* 2020;34:984–93.
17 Chattopadhyay S, de Kok B. Making research ethics work for global health: towards a more agile and collaborative approach. *BMJ Glob Health* 2023;8:e011415.
18 Price HD, Bowyer CJ, Büker P, *et al*. From reflection diaries to practical guidance for transdisciplinary research: learnings from a Kenyan air pollution project. *Sustain Sci* 2023;18:1429–44.
19 Bagha Z, Ayo-Olagunju T, Feyisara K, *et al*. The flight-related carbon footprint of the Pan-African Thoracic Society (PATS) methods in epidemiologic, clinical and organizational research (MECOR) course 2023. *JPATS* 2023;5:11–6.
20 Evertsz N, Bull S, Pratt B. What constitutes equitable data sharing in global health research? A scoping review of the literature on low-income and middle-income country stakeholders' perspectives. *BMJ Glob Health* 2023;8:e010157:8–3:.
21 Kalumbi L, Caes L, Chamba M, *et al*. n.d. Engaging with communities and policymakers around solutions to reduce the harm from household air pollution and solid fuel use in informal settlements: the Fuel to Pot project in Kenya and Malawi (Under Rev). *BMJ Glob Heal*.