Unequal 'Partners'.

AIDS, Academia, and the Rise of Global Health

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Abstract:

The last decade has seen the proliferation of "global health" departments, centers, programs, and majors across top research universities in North America and Europe. This trend has been particularly pronounced in the United States, where it is connected to America's new role as a major sponsor of HIV treatment in Africa. This paper describes the rise of "global health" as a research, funding, and training priority within U.S. academic medicine, and the increasing desirability of "global health partnerships" with institutions in sub-Saharan Africa. Leading spokespersons emphasize that "partnership" with poor nations is central to the mission of global health, an ethic that distinguishes it from older, more paternalistic traditions of international health and tropical medicine. However, at the same time, the field of academic global health depends on steep inequalities for its very existence, as it is the opportunity to work in impoverished, low-tech settings with high disease burdens that draws North American researchers and clinicians to global health programs and ensures their continued funding. This paradox – in which inequality is both a form of suffering to be redressed and a professional, knowledge-generating, opportunity to be exploited – makes the partnerships to which global health aspires particularly challenging.

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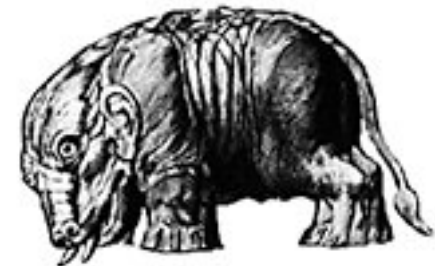
Intr oduction: Epidemics and Opportunities

Nearly 30 years ago, the U.S. Centers for Disease Control published a brief but unsettling account of a mysterious outbreak of an unusual pneumonia, Pneumocystis carinii, in several otherwise healthy young gay men (CDC 1981). In retrospect, the disease that would later come to be called AIDS can be seen as the first in a series of "emerging infections" that would spring into public and scientific awareness over the next several decades. The appearance of HIV and AIDS, along with the Ebola virus, BSE or "mad cow disease," SARS, MDR- and XDR-TB, H5N1 ("bird flu"), H1N1 ("swine flu"), and MRSA [1] led some to declare that infectious disease – supposedly vanquished in the post-World War II era of antibiotics – had in fact "returned" with a vengeance (Garrett 1996; Fauci 2001). More often than not, these threats were framed as emerging from poor countries in the global South to endanger wealthier, whiter populations in the global North (Anderson 2000; Farmer 2001; Patton 2002).

Much has been written about this "emerging infectious diseases worldview" in the medical social sciences (King 2002). Often, this literature has focused on the sense of crisis that surrounds these new and renewed epidemics and the development of biopolitical enterprises designed to manage "risky" and "at-risk" bodies and populations in an increasingly globalized and mobile world (Bourgois 2000; Collier/Lakoff 2008; Nguyen 2005a). The purpose of this paper is somewhat different, and seeks to bring a critical eye to a different and perhaps under-theorized consequence of the AIDS epidemic and the "return" of infectious disease. I speak here of the meteoric rise of "global health" as a field of practice and an academic discipline. In U.S. universities in particular, the number of programs, centers, institutes, and departments devoted to global health has skyrocketed in the last decade. Unlike the emerging infectious diseases worldview, which operates primarily within a register of fear (of disease) and protection (from disease), academic global health approaches AIDS and other infectious diseases as an opportunity for learning and for the production of scientific knowledge. In this scenario, rather than (or often in addition to) being quarantined, cordoned, or subject to other forms of biopolitical control, nations and regions suffering from a high burden of infectious disease are enlisted as "partners" in an educational endeavor. In this way, untreated epidemics are simultaneously envisioned as a socio-medical ill and instrumentalized as a scientific asset by American universities seeking to engage in "global health" activities.

Using ethnographic data collected at the meetings of the Consortium of Universities for Global Health (CUGH) and within a U.S.-Uganda research collaboration, this article represents an initial effort to historicize the current popularity of "global health" in the American academy and to think

[1] Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Bovine Spongiform Encephalopathy (BSE), Severe Acute Respiratory Syndrome (SARS), Multi-drug Resistant and Extensively Drug Resistant Tuberculosis (MDR- and XDR-TB), and Methicillin-Resistant Staphylococcus aureus (MRSA).

critically about the new kinds of relationships that are being established between the global North and South in the name of global health. In particular, I am interested in the ways in which global health is forging new kinds of ties between the United States and sub-Saharan Africa.

Global Health and the New Scramble for Africa

As of 2008, nearly half of U.S. medical schools and their affiliated institutions included "initiatives, institutes, centers, or offices" dedicated to "global health" (Crump/Sugarman 2008). This is a new phenomenon. Global health courses, majors, and minors have become increasingly "hot" within undergraduate programs (Brown 2008), and in response to student and faculty demand for global health opportunities, universities are both founding new departments and changing the names of existing programs to ally themselves with this emerging field. [2] A 2009 survey showed that total of forty-one universities in North America (mostly in the U.S.) have created "pan-university institutes, centers, and the like" devoted to global health, and that an additional eleven schools have established global health programs within existing departments or divisions (Merson/Page 2009, 3). Furthermore, many schools house international learning or research endeavors which, while clearly of a "global health" nature, are not officially administered by the university's office or department of global health. Notably, the growth of interest in global health is significant enough that non-academic entities are seeking to capitalize on it: for example, Seattle's Chamber of Commerce recently launched an organization called the Washington Global Health Alliance in an attempt to harness the city's sizable global health activity – some have called it an 'industry' – for local economic development (Paulson 2008; Heim 2010). Similarly, a recent conference in Boston touted "New England's Strategic Advantage" in the field of global health, pointing to the region's high concentration of research institutions and bioscience companies. [3] Thus, in the U.S., "global health" is emerging as a powerful force for mobilizing resources and action both within and outside the academy.

Academic global health programs encompass a wide variety of activities and include a broad range of participants, from first-year undergraduates to internationally-known research scientists. For example, activities housed under the umbrella of "global health" may include overseas service learning programs for college students, international clinical rotations for medical students and medical residents, and/or medical and public health research conducted in the global South, often in collaboration with foreign colleagues. What ties these varied activities together is their operation in what the medical literature refers to as "resource-poor" or "resource-limited" settings. Specifically, the

[2] For example, the University of Washington established a new Department of Global Health in 2007 (http://globalhealth.washington.edu/about_us/chairmsg.php), and Harvard changed the name of its Department of Social Medicine to the Department of Global Health and Social Medicine in 2008 (http://ghsm.hms.harvard.edu/about/history/).

[3] See http://harvardscience.harvard.edu/culture-society/articles/panel-examines-new-england-s-contributions-role-global-health.

existence and success of such programs depends upon the ability of U.S. universities to establish ties with clinics, teaching hospitals, and universities in the global South willing to serve as hosts for American students, medical residents, and research faculty wishing to "do" global health. Countries in eastern and southern Africa (particularly Uganda, Tanzania, Kenya, and Botswana) have become some of the most popular locations for U.S. academic global health programs in search of host institutions, as they offer relative political stability as well as an English-speaking elite due to their status as former British colonies (American Universities' Engagement in Global Health 2009). [4]

In the course of my research, more than one American HIV researcher has described the rapidity of this expansion to me with some concern. As U.S. research universities rush to establish partnerships that can give their students and faculty opportunities to work in "resource-poor" African settings, some have expressed worry that the juggernaut of global health is engendering a 21st-century academic "scramble for Africa" (see also Nguyen 2009, 206). Perhaps in response to these postcolonial anxieties, the term "partnership" has emerged as a key word within this new arena or "social world" of global health [5] (Clark/Star 2003). Host institutions in Africa and elsewhere in the global South are described as "partners," and Northern global health leaders cite "real" or "true" partnership with poor countries as a key factor distinguishing global health from its predecessor fields of international health and tropical medicine, which are seen as having operated in a more top-down, paternalistic mode (Koplan 2009). In contrast, this paper starts from the premise that "global health" – at least in the academic context described here – is primarily a North American concept, and aims to explore some of the discourses and practices that make it so (see also MacFarlane et al. 2008; Holm/Malete 2010).

'Global Health' as an ethnographic object

In my analysis, I draw primarily upon my experiences as a participant-observer at meetings of a nascent group called the Consortium of Universities for Global Health (CUGH). In addition, I supplement these observations with data collected during my fieldwork within a university-based, U.S.-Uganda HIV research partnership. The CUGH was founded in 2008 for the purposes of giving U.S. and Canadian universities active in global health a place to share ideas and experiences, and to shape the future of education and research in the field. In order to become a full member of the organization, a university must house a multidisciplinary global health program, pay $3500 in annual dues, and "have at least one substantive, current, long-term relationship with an international partner university in a low- or middle-income country" (Consortium of Universities for Global Health 2010). (Universities in low-income

[4] Examples include the University of California San Francisco's program at Muhimbili University in Tanzania, the University of Pennsylvania-Botswana Partnership in Gabarone, Harvard's research program at Uganda's Mbarara University of Science and Technology, Cornell University's relationship with Kilimanjaro Christian Medical College in Moshi, Tanzania, and Weill Cornell Medical School's partnership with Bugando University College of Health Sciences in Mwanza, Tanzania – recently renamed Weill-Bugando University of Health Sciences. In addition, there are a few notable examples of long-standing partnerships that predate the current popularity of "global health." These include the Johns Hopkins/Makerere University (Uganda) partnership and the Indiana University/Moi University (Kenya) partnership, both established in the late 1980s.

[5] See recent dissertations by Rene Gerrets and Elise Carpenter for ethnographic accounts of a malaria partnership in Tanzania (Gerrets 2010a) and an HIV/AIDS partnership in Botswana (Carpenter 2008).

countries that have existing partnerships with CUGH universities are able to join for free.) The organization's inaugural meeting was held in 2008 in San Francisco, and 50 representatives from 20 universities were invited to attend. The group's first annual meeting, held one year later in 2009, took place on the campus of the U.S. National Institutes of Health and was much larger, with over 250 attendees from more than 50 universities participating. Recently, over 850 people attended the 2010 meeting at the University of Washington in Seattle.

Why study an organization like the CUGH? In a now-classic essay on the importance of "studying up," Laura Nader urged anthropologists to turn their ethnographic attention not just to the poor and underprivileged, but to institutions of wealth and power. "Anthropologists," she argued, "have a great deal to contribute to the processes whereby power and responsibility are exercised in the United States" (Nader 1972, 284). The state of anthropology is different now than when Nader first published this piece in 1969, and the subject of power and its exercise is now a major focus of ethnographic studies both of the U.S. and elsewhere. Nonetheless, her intervention remains relevant, and provides a useful perspective from which to approach "global health" as an ethnographic object.

Although anthropologists have made important contributions to the analysis of postcolonial power relations within global health projects, especially in the field of HIV/AIDS (see, for example, Pigg 2001; Pfeiffer 2004; Nguyen 2005a,b; Farmer 1999), the ethnographic lens has not usually focused on the field's power brokers. Yet, it is these networks of experts or "epistemic communities" that have the power to "set agendas, frame issues, identify problems, and propose solutions" within global health (Janes/ Corbett 2009, 174). The CUGH brings together some of the most influential individuals and institutions in academic medicine today. Its meetings are populated by prominent and powerful researchers from the most prestigious universities in North America, as well as by a very select group of elite researchers from low-income countries. This high level of symbolic capital gives the CUGH considerable power over the shape and priorities of global health as a field, and makes it a particularly valuable venue in which to "study up." In doing so I follow not only Laura Nader's directive, but the urgings of James Pfieffer, Mark Nichter, and the Critical Anthropology of Global Health special interest group, who recently argued that medical anthropologists can make a valuable contribution to redressing inequality by "illuminating the social processes, power relations, development culture, and discourses that drive the global health enterprise" (Pfeiffer/Nichter 2008, 413).

Where analysis of the CUGH meetings provides an opportunity to interrogate the discursive field of North American global health leaders, it does not afford the chance to observe how "partnership"

between American and African actors and institutions is enacted in practice. For this reason, I include select accounts from my fieldwork within a university-based U.S.-Ugandan HIV research collaboration as a supplement to my discussion of CUGH. The formal aspects of this fieldwork were conducted over 12 months in the U.S. (2004-2005) and two months in Uganda (2005, 2009), though as a former employee of the project, my ties to both the American and Ugandan sides of the research group extend beyond these periods.

PEPFAR and the Rise of Global Health

"Global health" is often described as having emerged out of the older fields of tropical medicine and international health, though the question of whether it is truly distinctive is debated, even among those who describe themselves as within the field (Bunyavanich/Walkup 2001; Brown et al. 2006; Macfarlane et al. 2008). The phrase became increasingly visible in the 1990s, spurred in part by the WHO's efforts to "refashion itself as a coordinator, strategic planner, and leader of 'global health' initiatives" in an attempt reclaim some of the power and visibility it had lost to the World Bank's growing international health programs during the 1980s and 1990s (Brown et al. 2006, 69). Notably, as a term, "global health" appears most commonly in North America. For example, a 2008 search of the PubMed medical literature database found that 87% of articles by authors with affiliations with university global health programs were North American (Macfarlane et al. 2008, 389).

Recent anthropological and historical literature has focused on the interpenetration of global health with national security concerns in the late 20th and early 21st centuries, particularly within the U.S. (Lakoff/Collier 2008). For example, Nicholas King describes the rise of the "emerging infectious diseases worldview" in the 1990s, which emphasized the need for rigorous surveillance of global health threats and the integration of postcolonial economies into the global marketplace (King 2002). King and others describe a rising concern that epidemics (particularly AIDS) might further weaken fragile states and create a "nontraditional" national security risk to the U.S. – what Alan Ingram has described as "the securitization of disease" (King 2002; Ingram 2005). However, in a recent address to the Society for Medical Anthropology, Didier Fassin provided a reminder that the formulation of global health as a security issue co-exists with a second "semantic network" in which global health connotes compassion for the poor and a concern with global inequalities. These two frameworks are not necessarily contradictory, he argues, though

they are distinct (Fassin 2009). Furthermore, both frameworks are worthy of problematization; good intentions and compassionate action are not immune to the power imbalances and inequalities they seek to redress.

North American universities pursuing global health activities do so primarily within this second register of compassion, pairing it with a scientific mission in which international research and medical education are valorized as humanitarian endeavors ("saving lives"). Interrogating this invocation of "global health" allows us to see things that are not visible – or at least appear very different – from the security perspective. This is particularly the case with AIDS. From the security perspective, AIDS is emblematic of the emerging infectious diseases worldview, demonstrating the globalization of disease, the porousness of borders, and the threat posed to the American public by new forms of infection. By contrast, from the perspective of academic global health, AIDS seems distinctly rooted in place. Its primary symbolic register in this arena is not global, but rather African. Furthermore, the severity of the AIDS epidemic on parts of the African continent is envisioned not so much as a security threat, but as a scientific and humanitarian opportunity to "do" global health.

The current juggernaut of activity within academic global health has its roots in the African AIDS epidemic and recent U.S. government responses to it. Throughout the 1990s, U.S. doctors and researchers became increasingly aware of and concerned about the scale of the AIDS epidemic in parts of Africa (Fauci 2007), and activist pressure on donor nations to make antiretroviral therapies available in poor countries mounted. In the early 2000s, a major shift occurred with the establishment of the multilateral Global Fund to Fight AIDS, TB, and Malaria (to which the U.S. was the largest donor), and the President's Emergency Plan for AIDS Relief (or "PEPFAR"), which was initiated and funded entirely by the U.S. government under George W. Bush. Both programs offered substantial funding for the support of free antiretroviral treatment programs in low-income countries. With an initial promise of $15 billion over 5 years, PEPFAR represented both the "largest ever international public health program," (Rottenburg 2009, 424) and the largest expenditure the U.S. government had ever made towards a single disease (Jones 2010). It also ushered in an era of unprecedented involvement in African health by the American state and its collaborating institutions.

Significantly, PEPFAR funds travel not only through the U.S. State Department and government agencies such as the U.S. Agency for International Development (USAID) and the Centers for Disease Control (CDC), but also through both public and private U.S. universities. In 2007, three of the top ten PEPFAR grant recipients were American universities engaged in HIV treatment, prevention services,

and vaccine research in 13 different countries, 12 of which were in sub-Saharan Africa. [6] In addition, many other universities work with PEPFAR as "sub-partners" to primary grant recipients (PEPFAR 2010). In this way, the advent of PEPFAR has facilitated the expansion of American academic involvement in public health in Africa by laying some of the institutional groundwork for the establishment of global health partnerships between U.S. and African institutions.

Defining Global Health

The Consortium of Universities for Global Health (CUGH) is one organization that has emerged in recent years in response to the explosion of enthusiasm for global health on North American campuses. Initially funded by grants from the Gates and Rockefeller Foundations, the consortium currently includes 44 dues-paying member universities in North America and fourteen Southern "partner members" (all but one affiliated via either Johns Hopkins or the University of Washington) (CUGH 2010). Both CUGH membership and meeting participation have expanded rapidly since the group's initial formation three years ago.

One of the priorities of the CUGH's inaugural meeting in 2008 was to produce "a common definition of global health." As numerous science studies scholars have noted, defining the boundaries of what does and does not count as "science" is a powerful act, as it accords legitimacy to certain kinds of knowledge and practice while excluding others (Geiryn 1999; Epstein 1996). Likewise, as "global health" rises in scientific prominence and as a funding priority, the ability to define the field – and thus what lies outside it – becomes a powerful exercise in inclusion and exclusion. The CUGH's definition was published in 2009 on behalf of the consortium in a widely-cited article in the medical journal the Lancet (Koplan et al. 2009). In the published article, the CUGH authors are diligent about distancing global health from the older fields of international health and tropical medicine, which are seen as embodying outdated and paternalistic modes of relating between wealthy and poor nations. As such, they ally their preference for the term "global health" over "international health" to "a shift in philosophy and attitude that emphasizes the mutuality of real partnership, a pooling of expertise and knowledge, and a two-way flow between developed and developing countries" (Koplan et al. 2009, 1994). At the 2008 meeting, the lead author of the Lancet article made this point somewhat more bluntly, stating, "global health recognizes that the developed world does not have a monopoly on good ideas." In this way, North American global health leaders employ the idea of "partnership" to position the field morally by allying it with an ethic of equity that earlier incarnations of transnational health research and practice are seen as lacking.

[6] In 2007, Harvard University received PEPFAR funds for programs in Botswana, Nigeria, Tanzania and Vietnam; Columbia University ran PEPFAR-funded projects in Cameroon, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia; and the University of Maryland received PEPFAR funds for a vaccine research program in Nigeria (Avert 2008).

However, despite this aspiration to partnership, global health is in many ways a creation of the "resource-rich" world. This becomes evident upon comparing the Lancet article's definition of global health to the CUGH conference discussions that surrounded it. The second morning of the 2008 conference included a panel titled "Perspectives from Our Global Health Partners," which featured the four conference participants who had been invited to represent "partner" institutions in the global South. Of the 50 conference attendees, these were the only scientists not from U.S. or Canadian institutions, a fact that did not go unnoticed by some of the participants. (As one researcher from the Rockefeller Foundation noted in an aside, "If having an international partner is what got us invited to this conference, why weren't we required to bring our partners?") The four international panelists were senior academic researchers from Haiti, Mexico, Bangladesh and Uganda. The list of their Northern partner institutions read like a check-list of elite American schools – Harvard, Cornell, Johns Hopkins, Columbia, University of Michigan, and UCSF among others – plus government agencies such as the National Institutes of Health and the U.S. Agency for International Development. But unlike their American colleagues, who had spent most of the previous day in discussions about how to improve global health education opportunities for their undergraduate and medical students, the international panelists expressed uncertainty and sometimes skepticism regarding the term "global health" and what it meant to "do" global health.

For example, Mushtaque Chowdhury, Dean of the School of Public Health at BRAC University in Bangladesh, assured the audience that "what we do in Bangladesh is global health, though we don't call it global health." Mario Rodriguez-Lopez from the National Institute of Public Health in Cuernavaca Mexico – by his own account, the least well-known of the four panelists – recounted a conversation he had had the day before with Jeffrey Koplan, Vice President for Global Health at Emory University and leader of the CUGH's effort to forge a common definition of global health. Koplan had told him, "what you are doing in Mesoamerica is global health," to which Rodriguez-Lopez responded, "ah yes, I only just realized it!" Nelson Sewankambo, Principal of Makerere University College of Health Sciences in Kampala, Uganda and one of the first scientists to publish data on AIDS in Africa, was more confrontational. He told the room, "when you see it the way I see it, people are not discussing global health. […] How do our students learn global health? By coming North? By staying home? You need to examine what global health actually means from other countries' perspectives." Jean William Pape, an internationally known AIDS researcher from Haiti, echoed these sentiments by arguing in favor of a consortium that was global, rather than North American, in membership, telling the audience, "How

can you talk about collaboration when you are thinking one way and you don't even know how the other side is thinking? Yesterday we heard lots of issues relevant to Northern institutions. A global consortium is a great idea. You need to include partners early on."

Overall, the partners' comments seemed to reflect that what North American institutions were calling "global health" was simply public health, or "business as usual," in their countries (MacFarlane et al. 2008, 384). If this is so, Sewankambo's question is a provocative one: how do students from "host" countries in the South learn global health? One possible answer is that they travel North, requiring Northern universities to reciprocate their global health training programs by hosting students from Africa, Asia, and Latin America. The dean from BRAC University expressed a desire for such opportunities, but noted that whenever his students tried to travel to the U.S. they had trouble getting their visas approved (at which point, a Canadian researcher yelled out "come to Canada!," eliciting a laugh from the audience). Another possibility is that "global health" actually refers strictly to health care delivery and research in poor countries, which puts residents of these countries in the paradoxical position of needing to remain anchored in place in order to participate in "global" health. This question also arose during the 2009 meeting, when a Latin American member of the CUGH's Education Committee wondered aloud how Southern institutions might initiate global health partnerships, asking "what do you do, look for an even poorer country to work in?"

This tension over the meaning of "global health," and who gets to define it, was acknowledged by CUGH organizers both during the conference itself and in the report of the meeting's proceedings that was later published on the consortium's website. In the report – whose author is unnamed – the assertions that "global health is a Northern concept" and that "for the academic institution in the South, everyday public health, medical and nursing education and practices constitute 'global health'" are made on the first page (CUGH 2008). But, significantly, these important points were not included in the much more widely-read Lancet article that followed the conference, titled "Towards a Common Definition of Global Health," even though this article was co-authored by both Northern and Southern consortium members who attended the meeting, including some of the same researchers who had both made and acknowledged the objections described above. Instead, the Lancet article avoids any references to the postcolonial power dynamics of global health and speaks mainly in positive terms of its promise, offering up the following as a suggested definition: "global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide" (Koplan et al. 2009, 1995).

Bodies of Knowledge

In addition to clinical care and training programs, global health also encompasses a burgeoning transnational research apparatus aimed at studying and addressing health problems in the so-called "developing" world. One beneficial outcome of the fact that global health is currently "fashionable" in academia (Koplan et al. 2009) has been a growing attention to what researchers have dubbed the "10/90 gap": the critique that only ten percent of global expenditure on health research goes towards studying and fighting the diseases that most afflict 90% of the world's population (Global Forum for Health Research 2009). This awareness, along with increases in funding, have contributed to the prestige and desirability of international work in U.S. scientific circles, making global health research an increasingly rewarding career move for American clinical scientists. This shift has been led by the field of HIV/ AIDS research, which has witnessed a dramatic increase in the amount of work being conducted outside the U.S., particularly in Africa, in the last decade (Crane 2007).

American HIV researchers were drawn to sub-Saharan Africa both out of a humanitarian desire to assist the countries hardest hit by the AIDS epidemic and by the unparalleled research opportunities provided by the availability of large populations of HIV-infected individuals. Take, for example, a research meeting I observed at Mariposa University [7] in California in February of 2005. The meeting was attended by eight researchers from a variety of fields – epidemiology, biostatistics, public health, and medicine – and the agenda was to design a common research protocol that could be used across the university's growing number of HIV studies being conducted in Africa. The goal was to develop a standardized way of collecting social, behavioral, and biological information from African HIV patients participating in research, so that the data could then be "pooled" across studies conducted in different countries, creating larger and more powerful data sets for researchers to work with.

At this time, data regarding the advent of HIV treatment in Africa was of particular interest to these researchers. Free antiretroviral medications were just beginning to become available on the continent through PEPFAR and the Global Fund to Fight AIDS, TB, and Malaria, and the Mariposa scientists were eager to capture patients' biological information at "baseline," before they started therapy, in order to better document their response to treatment. This was particularly important because it provided a second chance to study the impact of HIV drugs on a large population of previously untreated people – a research opportunity that had been, in the words of the meeting's organizer, "lost" in the U.S. As the group discussed how large a blood sample would be necessary in order to obtain the desired biological data, Greg Robin, the physician-researcher leading the meeting, suggested that the African study

[7] The name of the university, as well as the names of researchers attending the meeting, are pseudonyms.

participants have their blood drawn twice, arguing, "I can't emphasize this enough – a biological specimen in the pre-treatment era is just golden to us. And 7mls of blood just isn't enough."

Afterwards I asked Dr. Jason Beale, another researcher in attendance, what Robin had meant when he said a research opportunity had been "lost" in the U.S. What Africa offered, Dr. Beale told me, was the possibility of studying the virus as it evolved in relation to exposure to drugs. The Mariposa researchers believed that knowledge about this evolution could provide useful information about both the pathophysiology and treatment of HIV. The opportunity to conduct such a study was lost in the U.S. because effective drugs became available here much earlier in the epidemic, before researchers realized what Beale called the "scientific value" of such a project. This recognition of scientific value would come later, after the development of viral load and drug resistance tests that allowed researchers to study the impact of antiretroviral drugs at the molecular level, rather than simply at the level of the patient's body (the clinical level). As a result, researchers did not begin to study the impact of treatment in this way until after drugs had been available for several years, and most U.S. patients had already been exposed to HIV medications. Thus, the opportunity to study the impact of HIV drugs on a large number of previously untreated patients in the U.S. was seen as "lost." This was precisely the opportunity that Africa now offered.

However, it is important to note that Beale and many of his colleagues were not driven by scientific ambition alone, but also by a moral and humanitarian commitment to promoting access to HIV medications in Africa, where the vast majority of the world's AIDS patients were dying (in part) due to lack of antiretrovirals. Beale's own African research on adherence to HIV drugs was undertaken in response to claims by experts and policymakers that the drugs would be wasted on impoverished patients, who (the argument went) would likely miss doses and facilitate the development of drug-resistant viral strains (Donnelly 2001; Popp/Fisher, 2002; Stevens 2004). Beale's work on antiretroviral therapy in Africa did take advantage of a scientific opportunity, but it was also a moral and political project aimed at using science to "prove" that Africans could indeed take the drugs properly, and should be given the opportunity to do so (McNeill 2003). In this way, global health can envision African patients both as suffering persons in need of treatment and also as "bodies of knowledge" capable of yielding valuable scientific information. This, in and of itself, does not make this research different from that conducted on patients in the United States or elsewhere. Research subjects and research scientists everywhere must balance between the clinical imperative to heal and the scientific priority of data production. What makes global health research different is the radical inequality and geographic distance

that underpin it, leaving the field haunted by a postcolonial power differential that it continually struggles against. In this context, the discourse of "partnership" between Northern and Southern institutions has emerged as a key strategy for confronting, at least rhetorically, the problem of inequality.

Postcolonial Partnership

Aspiring academic global health researchers in the North, such as those at Mariposa University, are not unaware of the dubious ethical conditions under which earlier international research was carried out. In the colonial and post-independence eras, American and European scientists often simply collected the data they wanted and left with little accountability to local communities or researchers. In global health circles, this style of science is referred to disparagingly as "parachute," "helicopter," or "safari" research. Instead, "partnership" with scientists and institutions in poor countries is advocated as an alternative, more equitable approach to conducting international research. Most often, this call to collaborate is aimed at African universities, which make up the bulk of global health partnership agreements with North American institutions (American Universities' Engagement in Global Health, 2009).

Partnership between American and African institutions provides U.S. researchers with access to desirable patient populations, as well as African colleagues qualified to shepherd proposals through local IRB approval. At the same time, partnership offers genuine benefits to African host institutions, including investment in infrastructure (such as laboratories, information technology, and buildings), job creation, and funded research opportunities for African investigators who might otherwise have little access to scientific grants. Many global health partnerships espouse an explicit commitment to "capacity building," and offer training in research skills to African physicians with the goal of fostering local expertise and leadership in global health science. Thus, "partnership" is not an empty promise, and there are many ways in which these alliances are mutually beneficial. At the same time, however, significant inequalities persist, and the promotion by Northern stakeholders of global health as a "win-win" example of "real partnership" risks mystifying this. As Rene Gerrets has noted in his work on public-private partnerships in global health, "the notion of 'partnership' and its emphasis on equality and consensus, stands at odds with the diverse social realities and dynamics among the sites and actors that global health partnerships typically engage" (Gerrets 2010b).

Within the context of the CUGH meetings, the term "partnership" played a prominent role, serving as a defining characteristic of the field of global health, a descriptor of the role played by Southern institutions and experts, and a qualifying condition for membership in the consortium. However, what

defined a "real partnership" – legally, administratively, scientifically, or otherwise – was not discussed leaving "partnership" as a vague idea that could be employed to many ends. For example, when meeting participants described challenges or inequalities they had encountered in their global health work, "partnership" was often proposed as the remedy. In one instance, a university president speaking at the 2009 meeting noted the need for "humility" in the face of global health interventions that had been unsuccessful. Citing a scenario in which donors had failed to realize that Sudanese recipients of insecticide-treated bed nets would want to wash the nets in order to remove the cooking smoke they collected (thus also removing the insecticide), he asked, "How will we do better in the future? By partnering with the people it impacts." In a different mode, at the same meeting, an NIH researcher described the reluctance of some U.S. institutions to participate in global health research out of fear of losing grant money to foreign collaborators. This anxiety could be assuaged, she said, by funding "partnerships" between domestic and foreign universities. In juxtaposing these two examples, we can see that the concept of partnership is being used to describe very different things: in the first case, a call for community-based public health intervention, and in the second, the creation of a transnational institutional structure for the purposes of administering research funds.

However, despite the frequent invocation of the idea of "partnership" in global health, the field has given little consideration to what partnership actually entails in practice or to the wide variety of relationships that currently exist between Northern and Southern entities. This lack of attention to the meanings and activities taking place in the name of partnership risks obscuring the diversity of arrangements and complex power dynamics at stake. In particular, the equity aspired to in the term "partnership" does not account for the fact that collaborations between American and African institutions often resemble donor/aid receipt relationships. Because these partnerships often bring material benefits in the form of new or renovated university facilities, updated laboratory infrastructure, additional faculty, and/or employment opportunities, they provide an important source of revenue and resources for underfunded African institutions. However, this assistance often comes with embedded assumptions about research and curriculum priorities that American funders (often unknowingly) impose on their African collaborators (Holm/Malete 2010). Furthermore, the resources and prestige that come with international partnership may exacerbate existing inequalities within host nations by disenfranchising universities unable to attract partners. For example, while partnership with a Northern university may bring much-needed resources to an African host university such as Nelson Sewankambo's Makerere University, the flocking of American partners to prominent, urban

institutions such as this one may at the same time further marginalize lesser-known Ugandan universities in more rural locations. [8]

The donor/ recipient dynamic within such partnerships is further complicated by rules set by funding bodies, most notably the U.S. National Institutes of Health (NIH), where much of the funding for American-sponsored global health research originates. NIH regulations cap reimbursements for "indirect costs" – i.e., administrative and infrastructural overhead – at 8% for foreign institutions. By contrast, American institutions, which negotiate this rate with the NIH individually, are reimbursed for indirect costs at much higher rates: for example, the reimbursement rate for federally funded research at Johns Hopkins School of Medicine is 64% (Johns Hopkins Medicine 2010). For example, if Hopkins receives an NIH grant for $100,000, another $64,000 will be added on to this to cover "indirect" overhead costs, but a foreign university receiving a grant of the same size would only be given $8000 to cover administrative expenses. The result is that universities in low-income countries in Africa and elsewhere are being asked to manage large scientific grants on behalf of global health partnerships, but are offered insufficient reimbursement for the administrative costs of doing so. I witnessed this in my own research, where the Ugandan organization established to serve as Mariposa University's local fiscal agent suffered a financial meltdown as U.S. interest in conducting research at the site grew and the number of projects it was expected to administer ballooned.

This problem did not go unrecognized at the CUGH meeting, where one American scientist noted that the low reimbursement rate was simply not enough for foreign universities to build the infrastructure needed to support international partnership. An eight percent reimbursement rate, he said, is simply, "not very partner-like." Or is it? While on some level this disparity in overhead reimbursement seems blatantly unfair, it is also arguable that in a "true" – i.e. truly equitable – partnership, one partner would not be responsible for subsidizing the operational costs of the other. [9] However, because of the steep economic inequalities that underlie these arrangements, the reality of "partnership" is that an African institution may asked to administer an NIH grant that is larger than its entire university budget, as one American CUGH meeting participant recounted. The result is a partnership that sets up the African participant for failure.

Conclusion: The Value of Inequality

Given the ongoing context of global socioeconomic inequality, how might these emerging disparities within global health partnerships and practices be ameliorated? Clearly, efforts to define the meaning,

[8] Thanks to Ghefari Elsayed for highlighting the importance of this dynamic for me.

[9] Thanks to Richard Rottenburg for alerting me to this point.

scope, and mission of "global health" need to be more inclusive of perspectives from low-income nations – otherwise, claims of partnership are likely to remain strictly aspirational rather than actual. To do this, scholars from poor and middle-income countries need to be included in larger numbers and at higher levels in organizations like the CUGH, lest such groups become de facto clubs of North American academic power brokers. At the CUGH meetings, there was some awareness of this problem among North American participants. For example, in a discussion concerning the membership status of Southern "partner" institutions at the end of the 2009 meeting, one CUGH board member noted that "there is lots of discussion about how low and middle income partners should participate, but there are no representatives from a partner institution in the room."

However, the challenges to equity within global health go beyond issues of definition and representation. In addition to making global health more inclusive, U.S. universities must come to terms with the fact that the very poverty and inequality that they aspire to remedy is also what makes their global health programs both possible and popular. In other words, in the world of academic global health, inequality is a valuable opportunity. In making this assertion, it is by no means my intention to reduce academic global health to opportunism. Although both American and African scholars and institutions may benefit from global health partnerships, their participation is motivated not only or even primarily by scientific or career ambition, but also by a genuine compassion for patients and a humanitarian desire to ease suffering. However, as the work of Fassin and others has shown us, humanitarian efforts do not stand outside politics, and humanitarian actions should not be above examination and critique (Fassin 2010; McFalls 2010).

The legacy of colonial-era power relations is an uncomfortable topic in global health, and one which the field seeks to avoid reproducing through the invocation of an ethic of "partnership." However, as I hope this paper has shown, the espousal of partnership – while a noble aspiration – runs the risk of obfuscating both the enduring and novel forms of inequality that shape the transnational relations of global health. This includes the dependence of Northern global health programs on easy access to the bodies of under-treated patients in the global South, and the difficulty in envisioning how Southern clinicians and researchers might participate in global health. This complicated and paradoxical relationship to inequality is not usually addressed by Northern actors and institutions within the field, which tend to position their activities as straightforwardly beneficial for both the wealthy sponsor nation and the lower-income host country. To be fair, these programs do bring benefits to institutions in poor countries, and their presence is most often quite welcome. However, if global health wishes to

truly make strides towards its ethic of equitable partnership, the field must make a more genuine effort to grapple with the unequal terrain on which it operates and which, ultimately, serves as its condition of possibility.

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