

Parachute Research: Analysing the Unequal Power Relations in Global Health  
Research

African Contributions to Global Health

Essay

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Equity is at the heart of global health. Yet, approximately 85% of all global health research headquarters are in North America or Western Europe and are dominated by male board members (Global Health 50/50 2020). The picture here is not particularly diverse. Which is a particular problem as international cooperation is essential for combating global health issues. The Global North, i.e., Western academic institutions, drive global health research and their experts dominate the field.

This lack of equality reflects in the issue of parachute research. In parachute research, global health researchers collect samples from another country, return directly home and analyse them without consulting the people fighting the epidemic. The results are shared inadequately or not at all (The Lancet Global Health 2018). The reasons for this are often either the desire to publish in a prestigious journal or the opportunity to earn money with their own treatments for diseases. Awareness of safari or parachute research and its negative consequences is growing, but it is still a pressing problem in practice. Instead of fully using the expertise of scientists from African countries western scientists tend to use African scientists as data collectors for Western research agendas. This will most likely not change the health problems in these countries. For decades, international sponsors have been trying to improve a wide variety of health conditions on the African continent - with little success considering the overall picture. Instead of using the knowledge and research on the continent and adapting to the realities, they stick to their own research agenda and try to impose a Eurocentric vision of health on a completely different continent. In the context of global health, this phenomenon is particularly pronounced in Africa, where the continent is highly vulnerable to infectious disease outbreaks. In part, this is due to insufficient investment in health infrastructure and scientific research (Yozwiak et al. 2016). It attracts foreign attention for assistance, as a disparity in health care and disease surveillance can cause local outbreaks to become global infectious threats.

In the following, I will provide two examples on how crucial discoveries in the field of global health have been claimed by Western researchers without acknowledging the scientists from Africa.

Let's take the example of Jean-Jacques Muyembe, a Congolese doctor who discovered Ebola and to this day fights for real recognition. If you google "who discovered Ebola?" you get a multitude of white male researchers from the West. In fact, Dr Peter Piot from Belgium gets a lot of credit for discovering Ebola: he obtained blood samples from Muyembe to isolate the virus. He is widely and mistakenly regarded as the man who "discovered" the disease and has even written a book about "his" discovery. In his book, he only mentions Dr Muyembe in passing as a clever scientist who provided him with resources, without giving him credit for actually discovering Ebola. African scientists were simply excluded from the first Ebola outbreak. White scientists parachuted into the country, took samples, wrote an article, and published it in respected Western journals. They wrote the story wrong ('The Co-Discovery of Ebola's Road to Recognition' 2021). This was also the case with malaria. Somali nomads told the renowned British ethnologist Sir Richard Burton in 1856 that malaria is transmitted by mosquitoes, which the latter dismissed as "superstition". Forty-one years later, the British doctor Ronald Ross received the Nobel Prize for this "discovery" (Burton 2004).

Despite the high burden of infectious diseases on the African continent, studies show that there are few contributions to the biomedical literature by African researchers. The numbers have slowly increased in recent years, but are still quite low compared to the high burden of infectious diseases (Tonen-Wolyec et al. 2022; Mègnigbèto 2013; Tonen-Wolyec et al. 2022) . That is because in international collaborations of studies in Africa, African authors are underrepresented, with non-African researchers usually falling into key authorship. Namely the first and last authorship position. Worldwide, authors from the USA and Western Europe account for 80% of published articles in infectious disease journals. However, most infectious diseases occur in low- and middle-income countries, and certainly not in the USA or Western Europe. This shows an unequal research partnership at the level of the global health community (Mbaye et al. 2019). So why is authorship so important? Authorship represents the position of the scientists in the decision-making and research governance of the project. It therefore determines the decision-making process and capability to negotiate for African scientists in their countries. The position of an African scientist as first or last author can change the research agenda by giving them the opportunity to take the lead.

The current funding structures in global health create a power imbalance in favour of Western institutions. In doing so, Western institutions sustain inequalities in access to funding

through policies that often exclude African institutions. For example, the non-profit organisation PATH announced a US\$350 million grant to the US government's President's Malaria Initiative (PMI) (Erondu et al. 2021). The grant supported institutions in the US, UK and Australia to fight malaria in Africa, but not a single African institution was mentioned in the press release. These kinds of structural inequalities need to be addressed in global health research. In international collaborations, researchers from high-income countries control funding and can therefore dictate research agendas in Africa. Most research projects on the African continent are in collaboration with non-African institutions. The question on equal partnerships is therefore highly relevant (Mutapi 2019).

Dr Muyembe is currently no longer giving blood samples for Ebola studies because of the way he was treated. This is causing frustration in the international research community, but it is a powerful sign that perhaps is raising awareness about the issue. This illustrates the problem that important research for global health is being held back out of disregard for scientific discoveries from Africa. To date, the website of the Institute of Tropical Medicine in Antwerp claims that "ITM researchers Guido van der Groen and Peter Piot co-discovered the Ebola virus, which was first studied in Zaire in 1976". Dr Jean-Jacques Muyembe is mentioned on the website, but there is no picture of him, nor is he mentioned by name as one of the scientists who co-discovered Ebola. This example reflects the power relations in global health and science in general. However, there may be a ray of hope; Dr Muyembe has finally received due recognition and been awarded a patent for developing the first Ebola treatment. He has also received several international awards such as the Royal Society Africa Prize and the Hideyo Noguchi Africa Prize. Perhaps these power relations in global health will change after all.

Primary research in low- or middle-income countries without substantial involvement of local collaborators should have no future in global health research. Often the idea resonates that researchers from high-income countries bring knowledge and expertise to countries that are hard to come by, so having someone from outside makes a real contribution. Yet the local scientists have gathered experience and local knowledge about diseases such as malaria, AIDS, and meningitis. These diseases have plagued millions of their families and friends for a long time. The role of the "global South" in this co-production is often neglected, and scientists are seen merely as resource providers. The decentralisation of knowledge production could be a possible solution to the problems presented. We need to see the African continent as a co-producer of knowledge and stop applying our western research agendas to the problems arising in that country. We need to *decolonise global health*. The movement to *decolonise global health*

demonstrates the dismantling of structures that promote unequal power relations of knowledge (Erondu et al. 2021).

In conclusion, the problem is not international cooperation in health research per se. Rather, it is the nature of the collaboration and how the recognition is distributed. Above all, it should be a true partnership of equals, where the contributions of local researchers and experts are valued as much as those of scientists from abroad. Looking ahead, the first step is to recognise parachute research as a chronic problem. Secondly, one solution could be to make collaboration a fixed condition for data use, i.e. if researchers from the North want to use data produced in Africa, they must involve the local researchers who produced the data. Of course, care must be taken that authorship is not given away.

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