Addressing complexity and political economy in health research capacity strengthening:

Independent researchers working to institutional and national development agendas in an era of globalization of knowledge

ALASTAIR AGER, Mailman School of Public Health, Columbia University, New York (aa2468@columbia.edu)

CHRISTINA ZAROWSKY, School of Public Health and Centre for Research in HIV and AIDS, University Of Western Cape , Cape Town (czarowsky@uwc.ac.za, czarowsky@gmail.com)

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Summary

This working paper draws upon a program of research and reflection on the dynamics of health research capacity strengthening which engaged with initiatives across southern, eastern and West Africa. The HRCS Global Learning initiative sought to promote reflection and exchange to enhance individual and collective engagement with the science, art, and politics of strengthening capacities in complex contexts. This paper first reports on the outcomes of the concluding symposium – including a multi-dimensional scaling analysis of the common challenges in health research capacity strengthening put forward by the participants – and then discusses the synthesized findings of the programme in relation to the wider political economy of global health research.

Symposium participants identified 10 distinct but interconnected clusters of challenges: securing long-term funding, establishing sustainable models of capacity strengthening; ensuring Southern ownership; engaging researchers, policymakers and donors; securing trust and cooperation; finding common interest; addressing disincentives for academic engagement; accommodating local health system priorities and constraints; establishing and retaining research teams; and sustaining mentorship and institutional support.

Reflecting other recent analyses, the above suggests something of the complexity of health research capacity development. We argue that there is a somewhat unique political economy influencing the shape of such efforts which has received inadequate recognition, with three key drivers:

- an enduring model of independent researchers and research leaders;
- the globalization of knowledge and the linked mobility of (elite) individuals; and
- institutionalization of research capacity within universities and research centres and, increasingly, national research and development agendas.

Strategies for health research capacity strengthening that fail to acknowledge the complex agendas and competing influences deriving from these three drivers are likely to be ineffective. Institutional agendas (and their potential conflict with the reciprocal values of a ‘community of science’ linking individual researchers in a shared research or public health agenda) appear to be infrequently appropriately problematized. Health research capacity strengthening strategies couched in terms of institutional development are clearly at risk for ‘capture’ by independent researcher interests that are incentivized more strongly than institutional goals. Conversely, institutional strategies for capacity development that fail to acknowledge the ‘social capital’ of trust and collegiality between independent researchers linked
through global or local, “infra-institutional” interaction that enables and sustains partnership, makes them vulnerable to individual mobility (and ‘south-north’ capacity strengthening).

Our reflection on the three drivers in the political economy of global health research and capacity leads us to envisage at least three alternative scenarios. We suggest that each of these scenarios is currently at play both in African and Northern universities and among funders and policy makers, championed sometimes by different voices and sometimes by the same actors speaking from different constellations of interests and positionality. These scenarios may be characterised as follows:

- **Embrace Globalization and the Global ‘Community of Science’**: This scenario sees global mobility of health science (and health scientists) as an inevitable and appropriate goal.

- **Protect National and Institutional Agendas**: This scenario requires that we articulate more clearly the legitimate role of national and institutional agendas, and thus the legitimacy of power and incentives that constrain the ‘independence’ of researchers (in terms of focus of their work or mobility).

- **Specify a Range of Coherent, Pragmatic, Acceptable Models Between These Extremes**: This scenario articulates a model that acknowledges growing globalization and mobility of knowledge and its producers, but in a complex and unequal landscape both within and between countries and institutions. It envisions a range of models and the “unbundling” of functions and roles traditionally held by universities, but interrogates rather than assuming unproblematized “elite” institutions, perfect connectivity, mobility, and yet somewhat paradoxically an increasing local, grounded relevance.

The experiences and analyses gathered together through the HRCS Global Learning programme suggest that the third scenario is already the emergent, complex reality.
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I. Introduction

Health research capacity strengthening in the global South has become a major development agenda. Key in this move have been arguments for the importance of national health research capacity to support locally-relevant evidence-based health policy and practice (Bennett et al., 2011; ESSENCE, 2011; Bates et al., 2011; Whitworth et al., 2010). This paper draws upon a program of research and reflection on the dynamics of health research capacity strengthening which engaged with initiatives across southern, eastern and West Africa. The HRCS Global Learning program compiled inventories of support for research capacity strengthening at individual, institutional and systems levels across the continent (Shamu, 2012) and mapped institutions engaged in health research training (Yarmoshuk, 2011, 2012; Yarmoshuk and Zarowsky 2013). It also commissioned critical reviews of institutional arrangements for health research capacity strengthening as well as evaluative reflections of experiences in research capacity strengthening in public health, including cross-cutting themes such as gender and power (Amde and Lehmann 2012; Kouanda and Bocoum 2012; Larkan 2012; Luna and Ager 2012; Ager and Afenyadul 2012; Ridde et al, 2012; Van Wyk 2012; Zarowsky and Morrell 2012), analyses focusing on national and regional health research systems development (Chanda-Kapata et al 2012; Marais et al 2011), and reflections by African health research leaders on key principles for supporting health research capacity development (Ager and Zarowsky, 2012). It was informed by symposia, workshops and other activities supported through a linked IDRC-funded project, “Strengthening African Research for Responsive Health Policies and Systems” undertaken by UWC’s School of Public Health and Centre for Research in HIV and AIDS including especially an international symposium on “Public Health in the Age of HIV” (Zarowsky and Lehmann 2010) and a research project and workshop on “Situating research in public health training and practice: current debates and emerging good practice” (Zarowsky and Morrell 2012), with subsequent engagement in the development of ASPHA (the Association of Schools of Public Health in Africa) as well as several capacity strengthening and MPH impact assessments funded by the European Union (CHEPSAA), WHO and the Bill and Melinda Gates Foundation (UWC WHO Master’s Programme in Health Workforce Development), the Commonwealth Foundation, Atlantic Philanthropies, IDRC, VLIR-UOS, PEPFAR/CDC, and others. The individual reviews and analyses were collated into a series of 22 briefs, “Learning about Research Capacity Strengthening” (Zarowsky and Ager 2012); the series, the
individual briefs, and the references to and/or full reports for some of the reviews are available at http://www.hivaids-uwc.org.za.

The project, and this paper, drew also on the individual and shared experience of the Project Leaders/co-authors as academics in African and North American universities and as funders working with Canadian and U.K. agencies committed to research capacity strengthening, including the DfID-Wellcome Trust-IDRC Health Research Capacity Strengthening Initiative for Kenya and Malawi which generated and incubated the HRCS Global Learning project.

It concluded with a symposium ‘Learning About Research Capacity Strengthening: Reflections on Challenges, Strategies and Culture’ at the Global Forum for Health Research meeting in Cape Town in April 2012, where over forty invited stakeholders reflected upon common challenges and potential strategies for health research capacity strengthening. The Symposium sought to deepen understanding and constructively engage with the institutional, politico-cultural and interpersonal dynamics that are experienced at all levels of capacity strengthening by people working in the field but which are seldom captured in proposals, workplans, and outputs-based evaluations (often reduced to numbers of workshops or graduates) of capacity strengthening efforts. Overall, then, the HRCS Global Learning initiative sought to promote reflection and exchange to enhance individual and collective engagement with the science, art, and politics of strengthening capacities to address complex problems in complex contexts.

This paper first reports on the outcomes of the concluding symposium – including a multidimensional scaling analysis of the common challenges put forward by the participants – and then discusses the synthesized findings of the programme in relation to the political economy of global health research.

II. Common Challenges in Health Research Capacity Development

After a period when participants were facilitated – through active groupwork – to recurrently reflect on recent experiences of health research capacity strengthening, participants at the ‘Learning About Research Capacity Strengthening: Reflections on Challenges, Strategies and Culture’ symposium were asked to suggest the three major challenges that faced those seeking to facilitate such work. Thirty-seven participants wrote brief descriptors of challenges on large ‘post-it’ notes, which were – following the meeting – collated after the fashion described in more detail by Ager et al. (2012).

In this instance, the procedure involved the sorting of a total of 110 items by four independent raters (all of whom had been present at the meeting). Raters independently sorted items into piles on
the basis of common themes, with no restriction on numbers of themes identified. For each rater a 110 x 110 concordance matrix was generated which signaled for all item pairs whether that rater had grouped them together (1) or apart (0). Concordance matrices for the four raters were then consolidated into a single 110 x 110 agreement matrix, which for each item pairing noted the proportion of raters that had grouped those two items together (providing a ratio between 0.0, never, and 1.0, always). This agreement matrix was then analyzed using Multi-Dimensional Scaling (MDS; Shepard, 1962; Torgerson, 1965). MDS is an exploratory technique used to derive structures that represent relationships between items in a visual manner (Mugavin, 2008).

Analysis generated a two-dimension map where proximity of items represented the probability that they were grouped together by raters (i.e. two items grouped together by all raters are positioned close together; two items never grouped together by any rater are positioned far apart; two items grouped together by some raters and not others are assigned intermediate proximity). The MDS map was reviewed to identify discrete clustering of items using indices of item density and proximity. The items comprising each of these clusters were then independently reviewed by three researchers who produced preliminary thematic labels – which were then consolidated into consensus themes - representative of the content of that grouping. Figure 1 shows the clustering of items and the consensus labels for each thematic grouping. This two-dimensional map accounts for 80.7% of total variance in item grouping, and was thus deemed to represent a valid basis for interpretation of the overall patterning of items.

Figure 1: Map of emerging clusters with assigned thematic labels
Ager & Zarowsky (2013) Political Economy in Health Research Capacity Strengthening

The map identifies ten distinct – though clearly related challenges. These are considered in turn below, progressing through the clusters identified in Figure 1 in a broadly clockwise direction.

**Securing Long-Term Funding**

A number of participants identified the long-term funding required for meaningful capacity strengthening as a major challenge. While for some it was the lack of availability of funds *per se* that presented difficulty, others noted it was the mis-match between the availability of short-term funding for specific research initiatives and the requirements for longer-term investment in capacity that was the principle source of difficulties. Many of the HRCS Global case studies had noted this tension, including the review of health research capacity strategies in West Africa (Ridde, 2012). In another, Luna and Ager (2012) had analysed the tensions of seeking to build long-term partnership for a north-south collaborative doctoral training program on the basis of a specific short-term funding source.

**Establishing Sustainable Models**

Closely linked to the concerns of long-term funding was the establishment of sustainable models of health research capacity development. Sources of financing remained a central concern here (particularly addressing the lack of host government investment), but so too were time scales in expectations of research activity. Some participants noted the lack of interest in investing in ‘novice’ researchers, for example, while others observed that researchers were principally drawn by incentives ‘to consultancy not research’ (a theme elaborated later).

**Ensuring Southern Ownership**

The next cluster of issues extended this concern to broader issues of southern ownership. As one participant observed a key question is ‘how to support southern-led priorities when much of the funding focus is northern / funder driven?’ Other contributory issues to this challenge were seen as weak south-south linkages (including lack of connection from Anglophone to Francophone and Lusophone contexts) and the loss of skilled researchers from the south (what one participant referred to as ‘the South-North research capacity strengthening initiative’).

**Engaging Researchers, Policymakers and Donors**

Many responses reflected on the different interests of researchers, policymakers and donors and the difficulties in bridging between these agendas. Without honest exchange, and an acknowledgement of
the differential power at work in seeking to resolve tensions in perspective, the notion of ‘equitable partnership’ was seen as illusory. The lack of a clear national research strategy was seen as an additional potential contribution to difficulties, with others pointing to the frequent lack of clear policy demand from policymakers in the health sector as a related constraint.

**Securing Trust and Cooperation**
The next domain developed this analysis of challenges in engagement with multiple-stakeholders, with greater emphasis on issues of commitment, understanding and trust. ‘Managing expectations and maintaining trust through operational friction’ had emerged as one of the major themes of the Luna and Ager (2012, p. 2) case study of establishment of a collaborative, inter-institutional doctoral programme. Their analysis indicated that inter-individual trust was pivotal in negotiating periods where formal inter-organizational relationships faltered, with one respondent suggesting ‘Institutions won’t trust each other; it is individuals that have to trust in each other’ (p. 29). Symposium participants echoed this theme with suggestions that contestations over understandings of appropriate approaches and associated ‘power battles’ regularly needed to be addressed, with another summarizing the core challenge as: ‘getting various stakeholders involved in health research to trust each other and work together’.

**Finding Common Interest**
‘Finding common interest’ reflected a cluster of issues positioned at the fulcrum of the preceding three domains and the one immediately following, and thus suggested as closely linked to these other concerns. The common theme was in relation to what one participant described as ‘the value proposition for health research capacity strengthening that will persuade [stakeholders] to invest’. Comments noted the lack of incentives for many stakeholders to engage in building capacity together, including ‘monitoring and evaluation work being undervalued in academe’, ‘competition between [both] researchers and institutions’, lack of shared language across disciplines and difficulties of connecting trainees placed with ‘northern’ institutions in to southern institutional and national capacity development strategies.

**Addressing Disincentives for Academic Engagement**
This next cluster of issues developed the analysis of disincentives specifically from the perspective of academics. Some were clear extensions of issues grouped in the preceding cluster, such as ‘the lack of
recognition for knowledge transfer activities within academic career development’. Others raised issues of the ‘per diem culture’ that incentivized workshop attendance and, more generally, the lack of attractiveness of research as a career in many southern contexts.

**Accommodating Local Health System Priorities and Constraints**

This domain focused less on issues within academia and rather more on issues in relating research to the ‘real world’ environment of health systems in low income settings. This included major constraints on capacity at district and provincial levels that undermined realistic expectations of local commissioning of research, and related difficulties of identifying ‘gaps’ in knowledge relevant to local implementation that could plausibly by filled by research. Acknowledging the broader drivers on the research foci of researchers it was acknowledged that even if successfully articulated there may be low adherence to local health priorities. One participant, hinting at such wider drivers, reflected on the challenge of ‘educating the donor ‘experts’ about what research is fascinating and important rather than pedestrian and “rational”’.

**Establishing and Retaining Research Teams**

The final two clusters positioned to the lower right of Figure 1 developed analysis of challenges in the academic environment to support health research capacity strengthening goals. Many comments focused on the notion of a ‘critical mass’ of researchers to establish viable capacity, and the barriers to achieving this. One participant noted ‘the lack of career rewards for catalytic, synthetic, cross-disciplinary building versus private research productivity’, with others reinforcing the notion with talk of ‘piece-meal’, ‘project-based’ and ‘fragmented’ support as all barriers to effective team-building. Retention per se was noted as a challenge, but the major focus here was on coordinating efforts effectively with a goal – as one participant noted – of ‘building research teams of young investigators as opposed to individual stars’.

**Sustaining Mentorship and Institutional Support**

The final domain elaborated on the institutional requirements for developing research capacity. Issues of securing IT and laboratory facilities were noted, as were requirements for effective systems of research administration. But the strongest emphasis was on issues of mentorship. ‘Mentoring for novice researchers’, the difficulty of finding time away from projects for ‘intensive 1-to-1 mentoring’ required,
‘difficulty of supporting an apprenticeship process over time’, ‘finding appropriate mentors....there are simply too few’ etc. represented the densest clustering of issues for the whole exercise.

III. The Complexity of Health Research Capacity Development: Reflections on Political Economy

Reflecting other recent analyses (e.g. Landau, 2012), the above suggests something of the complexity of processes of health research capacity development. Landau, for example, notes the influence of ‘fundamentally unequal resource endowments and incentive structures’ (p.555) in undermining many well-intentioned initiatives, echoing two of the themes highlighted above. He also reflects on the challenges in southern researchers being encouraged to focus principally on policy-oriented research given the role of northern players in shaping such policy agendas, and thus the difficulty of southern voices retaining ultimate authority over funding and research priorities. We join with Landau in suggesting that technocratic strategies to address health research capacity development issues have typically ignored the realities of ‘the political economy of knowledge production’ (p. 558) that shapes such efforts.

In particular, reflecting upon the challenges and the documented experience of health research capacity strengthening through the HRCS Global Learning work, we believe that there is a fairly unique political economy influencing the shape of such efforts which has received inadequate recognition. Specifically, compared to other sectors and industries where capacity development is a pertinent issue, health research capacity development appears to be marked by three specific factors outlined below.

Independent researchers
The goal of capacitating ‘independent researchers’ is prominent within the discourse of health research capacity development. Despite some moves towards ‘team science’, the model of individual senior researchers leading research groups remains the dominant model of health research (and, crucially, major health funding mechanisms) in the northern hemisphere. Such ‘principal investigators’ are generally assumed to operate within a framework of academic freedom that provides them with the discretion and autonomy of individual research scientists. Transferred to a southern context this model potentially fetishizes the development of ‘research leaders’, who then serve as (frequently over-committed) gatekeepers of resources and potential patronage. There are benefits of this model, but
there are major challenges with it in relation to programmatically and policy orientation research. As one of the research leaders interviewed as part of the HRCS Global Learning programme noted:

There’s a lot of goodwill from northern institutions, but the approach remains ‘in our own image’. I don’t think we hear enough southern voices challenging this. African scientists, like others, have been socialized into this approach, and those that fit in this framework can be quite successful. But there needs to be a community of people who conceptualize research in a new manner. The ‘lone researcher’ model doesn’t work well in the usual work environment, where teams are much more likely to be successful. Systems still reinforce this notion through talk of ‘Principal Investigators’ and their demonstrating capacity for ‘independent research’. It’s amazing with all the resources that have been invested in building research capacity globally that there’s not a new way – and new voices – more clearly emerging (Wafaa El Sadr, cited Ager and Zarowsky, 2012).

**Globalization of knowledge**

It is increasingly recognized that the researcher autonomy noted above is exercised within a globalized ‘knowledge industry’. This industry is characterized by a free flow of knowledge products, remarkable mobility of researchers and a global ‘community of science’ networking individuals. This development is potentially transformative of approaches to research capacity development, yet to date the focus has largely been on facilitation of knowledge sharing (through open access journals, for example) rather than implications for knowledge generation. Research implementation remains dominated by notions of geography, including in terms of ‘field sites’ for which local and international researchers have proprietorial (or semi-proprietorial) rights. Such rootedness in context has clear advantages for more culturally, epidemiologically and clinically informed research, but the forces of globalization increasingly make such ‘local’ knowledge widely available and offer prospects for engagement in research freed from spatial affiliation.

Two other aspects of globalization significantly shape the political economy of health research. First, the development of metrics such as associated with the WHO Global Burden of Disease Study (and the common framing of the Demographic and Health Survey and Multi-Indicator Cluster Survey) clearly drive an agenda of cross-national comparison and global learning. Second, health research funding from donors is increasingly articulated with respect to the ‘global good’ of knowledge products, not just their local utilization (which is seen as the province of national governments).
Institutionalization of capacity

Between the domain of the ‘sole trader’ independent researcher and the global market of knowledge production and transfer lies the domain of the institution. The institutionalization of capacity – within research institutes and universities – remains a key policy concern, both as a means to shape knowledge creation and to ensure (more) equitable or sustainable models of knowledge transfer. However, the above analysis suggests the complexity of such institutionalization. Within a globalized system, the ties of individual academics to institutions may be considered ‘tactical’ in terms of more or less durable mutual interests rather than *de facto* alliances determined by geographical requirements and labor market constraints. Institutions provide a ‘safe harbour’ for independent researchers to administer their research activities, and provide the broader academic environment (including students and teaching facilities) to enable their work. Researchers provide institutions the opportunity for profile and influence, both of which may support resource mobilization.

But as noted above, the differential incentives operating for researchers and their institutions can make such relationships fractious. Case studies provided much evidence of trust between researchers (i.e. independent scientists within a globalized network) being perceived as much stronger than that between researchers and their institutions, or between institutions – where “institutions” were seen as the overall body, usually a university, but sometimes a department or Faculty. As we discuss below, the idea of “institution” and, perhaps, the idea of a university needs to be problematized. The emphasis on relationships, mentorship, and collegiality among the symposium participants and in several of the project case studies suggests that researchers do not see themselves primarily as “sole traders”. The values driving many of them – including teaching, building capacity in Africa, multidisciplinarity, policy engagement, and knowledge translation – also include loyalty to colleagues and need more than a convenient individual office or primarily electronic relationships to be realized: researchers with whom we interacted also value local institutional affiliations for regular face-to-face interactions with trusted colleagues.

Implications of these three drivers of health research capacity strengthening political economy

Strategies for health research capacity strengthening that fail to acknowledge the complex agendas deriving from these three drivers are clearly likely to be ineffective. We suggest that many of the challenges noted in the above analysis stem from the competing influences of these drivers. For example, health research capacity strengthening strategies couched in terms of institutional development are clearly at risk for ‘capture’ by independent researcher interests that are incentivized
more strongly than institutional goals. Conversely, institutional strategies for capacity development that fail to acknowledge the ‘social capital’ of trust and collegiality between independent researchers linked through global or local, “infra-institutional” interaction that enables and sustains partnership, makes them vulnerable to individual mobility (understood as the ‘south-north’ capacity strengthening noted above).

More generally, institutional agendas (and their potential conflict with the reciprocal values of a ‘community of science’ linking individual researchers in a shared research or public health agenda) appear to be infrequently appropriately problematized, perhaps particularly so in recent efforts to strengthen institutional research management capacity. While these efforts represent a welcome recognition that there is a large gap between being a technically proficient and creative scientist on the one hand and being able to manage the large and complex teams, budgets, and partnerships increasingly characterizing health research on the other, they fail to recognize the equally large gap between corporate and institutional interests – and the attendant bureaucracies needed to administer “big science” and large institutions – and the individual and team interests and often messy rhythms of research. Most universities are not managed like creative industries or biotech startups – and neither are most funders able to tolerate ambiguity and risk, not least because the current financial crisis further entrenches the most conservative and narrow understandings of "accountability" (Natsios 2010). The “enabling environment” and “research culture” many of the Symposium participants prioritized speak to the need for trust, flexibility, and innovation understood in terms of change and some risk rather than as a short-form for “potentially commercializable intellectual property.” The recent ESSENCE guidelines for research costing (ESSENCE 2012) remind universities and research institutions that their research management and support systems should serve and support research and researchers, rather than the other way around. But it is not evident from the experience shared in the context of this programme of work that this is largely the case.

Indeed, it could be argued that at the institutional level many African universities are likely to be at the worst point with respect to a flexible, responsive enabling environment: completely weak universities at least leave the researchers alone to get what funding they can and do what they want (at the risk of per-diem and consultancy driven “survival research”); elite universities support and celebrate both local and globalized lone rangers, but mid-level or emerging universities, in trying to put systems in place and be “accountable” to national agendas and foreign funders, run the risk of stifling initiative and productivity through managerialism and bureaucratization which emphasizes compliance over creativity and collegiality. In the process, they risk losing their most creative and productive researchers to the
global knowledge economy because, in fact, the "individual researcher" model IS still the fundamental model of research.

This links also with national institutionalization efforts through attempts to negotiate national research agendas and national research systems. In an era of global flows of knowledge and research – with donor investment shaped by the expectation of securing ‘global public goods’ and national governmental investments in such agendas frequently below agreed targets to make them functional (Ministerial Summit on Health Research, 2004) – such efforts frequently appear inadequately articulated conceptually and politically.

IV. Conclusions: Alternative Futures for Global Health Research?

In his introduction to the IPPR/Barber et al (2013) report, An avalanche is coming: Higher education and the revolution ahead Lawrence Summers writes:

- The authors argue that a new phase of competitive intensity is emerging as the concept of the traditional university itself comes under pressure and the various functions it serves are unbundled and increasingly supplied, perhaps better, by providers that are not universities at all. Thinktanks conduct research, private providers offer degrees, Thiel Fellowships have more prestige than top university qualifications, and Massive Open Online Courses (MOOCs) can take the best instructors global. (Barber et al 2013: 1)

While this paper has focused on research rather than on higher education or the university per se, the IPPR report aligns with many of the issues this project has explored. Our reflection above on the three drivers in the political economy of global health research and capacity leads us to envisage at least three alternative scenarios. Indeed, we suggest that each of these scenarios is currently at play both in African and Northern universities and among funders and policy makers, championed sometimes by different voices and sometimes by the same actors speaking from different constellations of interests and positionality.

- Embrace Globalization and the Global ‘Community of Science’: This scenario sees global mobility of health science (and health scientists) as an inevitable and appropriate goal. The physical distribution of health researchers will become increasingly unimportant, with growing information technological capacity to connect researchers across the world. Institutional and national research agendas will become less influential, as a strong global community of researchers is established, with influence based upon merit and connectivity (rather than
location). In some ways, this scenario is most closely aligned with the vision of the IPPR/Barber et al report and its confidence in technological solutions to the challenges of communication, learning, and relationship.

- **Protect National and Institutional Agendas:** This scenario requires that we articulate more clearly the legitimate role of national and institutional agendas, and thus the legitimacy of power and incentives that constrain the ‘independence’ of researchers (in terms of focus of their work or mobility). It articulates and may either seek to resolve, reverse or respect the competing interests and power of nations and institutions (e.g. in North and South) rather than assuming common interest. At one extreme, this scenario sees the nurturing of small, local research institutions with flat management structures and strong links to local community and policy worlds. At the other, it prioritizes national and university productivity, service and knowledge needs to which individual researchers or teams should align.

- **Specify a Range of Coherent, Pragmatic, Acceptable Models Between These Extremes:** This scenario articulates a model that acknowledges growing globalization and mobility of knowledge and its producers, but in a complex and unequal landscape both within and between countries and institutions. It envisions a range of models and the “unbundling” of functions and roles traditionally held by universities, in line with Barber et al.’s (2013) analyses, but interrogates rather than assuming unproblematised “elite” institutions, perfect connectivity, mobility, and yet somewhat paradoxically an increasing local, grounded relevance for example with local urban development plans. The paradox in this scenario is real: both local contexts and global fluidity, both entrenched power relations and opportunities for autonomy and even subversion are at play, sometimes within the same setting. One option in this scenario is the development of key institutional/national/regional nodes that provide vital, sustainable services/functions to a global network of researchers – interacting with local settings and institutions that ground these global networks and researchers without necessarily limiting them to the local.

The experiences and analyses gathered together through the HRCS Global Learning programme suggest that the third scenario is already the emergent, complex reality. The real work of capacity strengthening and innovation happens in the interstices and relationships as much as the structures of research, and
we have seen a wide range of more and less successful initiatives in an equally wide range of settings. Our reflections lead us to agree with analyses emphasizing complexity and emergence in thinking about and working to enhance organizational capacity for social change (Aragon 2010), but we are concerned that enthusiasm for the much greater “face validity” and explanatory power of complex adaptive systems thinking as an alternative to linear and “engineering” models of organizational development not efface attention to the realities of political economy. Not every future is feasible: power, organizational and disciplinary and political cultures, resources, and history shape and constrain possibility.

Yet the resonance of themes, challenges and pivotal transformations across contexts as different as Burkina Faso and Columbia University suggests that we may have more in common than we realize. This initiative sought, in part, to build a community of practice sharing and learning across our respective experiences. We found that discussions about broad themes rapidly grew too abstract and stale to capture the richness of context or usefully address the myriad ways in which a few themes play out on the ground. The globalization that seems most promising to us is one which brings these local specificities into conversation, creating temporary but recurrent spaces in which to reflect, analyse, adapt others’ experience, and sometimes find enough common ground to join efforts and forces.
References


Ager & Zarowsky (2013) Political Economy in Health Research Capacity Strengthening

uwc.org.za/index.php/publications/4-hiv-a-aids-research-centre/hiv-a-aids-research-centre/140-soph-briefs


