

Mapping university global health partnerships

In *The Lancet* in 2011, Johanna Crane argued for a “21st-century scramble for Africa by US universities”,¹ as global health becomes “an increasingly hot field”.¹ This popularity can be tracked, among other ways, through the increase of global health partnerships (GHPs). Research has helpfully explored power inequities between partner institutions, bureaucracy, misplaced research priorities, their (un)sustainability, and their potential to contribute to medical skills shortages in low-income and middle-income countries (LMICs).^{2,3} However, the research has also missed something crucial because it has not captured something far more basic and

instructive: the geographies of GHP arrangements.

To this end, we have undertaken what we believe to be the first systematic analysis of the geographical distribution of university GHPs. Using the Times Higher Education World University Rankings 2015–16 as a starting point, we compiled a database of each of the top 100 institutions’ GHPs. We then used this database to map the geographies of these partnership arrangements.

Our map (figure) shows the clear geographic regions and institutions in LMICs—particularly universities in Makerere (Uganda) and Addis Ababa (Ethiopia)—that have been successfully strategic in forging partnerships with global north universities. Moreover, GHPs are not as clearly neocolonial as has often been argued,⁴ although clear linkages between Dutch and Indonesian

institutions, between the UK and its former colonies, and between US institutions and Haiti are clear.

The map also shows the substantial untouched regions that are in great health-care need and remain unpartnered (ie, north and central Africa and central Asia), as well as an absence of the kind of south-south coalitions so often advocated. Although the map is obviously an artifact of the sample universities, many of the top Asian universities tend to partner with US rather than LMIC institutions.

We are aware that recent partnerships—or those not openly advertised online—could have been missed by our search strategy in this dynamic field. For this reason, we have made the dataset publicly available, and invite colleagues to engage in the collective process of its editing to ensure the accuracy and representativeness of this open-access resource.

Our findings might be unsurprising, but warrant a return to Richard Horton’s question: “Who, then, is global health for?”⁵ This question draws attention to the complex politics that both drive and emerge from the geographies of GHPs. Interrogating these political drivers should be central to future global health research agendas.

We declare no competing interests.

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- 2 Lasker JN. Hoping to help: the promises and pitfalls of global health volunteering. Ithaca, NY: Cornell University Press, 2016.
- 3 Brown H. Global health partnerships, governance, and sovereign responsibility in western Kenya. *Am Ethnol* 2015; **42**: 340–55.
- 4 Horton R. Offline: is global health neocolonialist? *Lancet* 2013; **382**: 1690.
- 5 Horton R. Offline: the case against global health. *Lancet* 2014; **383**: 1705.



For more on the Times Higher Education World University Rankings 2015–16 see https://www.timeshighereducation.com/world-university-rankings/2016/world-ranking#!/page/0/length/25/sort_by/rank_label/sort_order/asc/cols/rank_only

For the publicly available dataset see https://docs.google.com/spreadsheets/d/1NGhB1WGn1nFfe77vs_Tz2NezxE_KDmnmzEjubmsgXQ/edit#gid=1251708298



Figure: Global health partnership map
Made with QGIS 2.14, Python2. World Base Map: Bjørn Sandvik (Thematic Mapping) on work by Erle Schuyler and Sean Gilles.

For the code of the global health partnership map see <https://github.com/jreades/GlobalHealthPartnerships>

For Thematic Mapping see <http://www.thematicmapping.org>