More than one way to be global: Globalisation of research and the contest of ideas

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Pratt and Hyder's (2016) article highlights the importance of achieving a new global health ethics that balances an appreciation of global interdependence against the need for ongoing protection of local interests. While Pratt and Hyder offer a promising framework for working towards these goals through the governance of global health research consortia, their framework is silent on the process of globalization itself—i.e. on the ways in which global networks *form.* This lacuna is significant because globalization is not a single process. Rather, globalization is a heterogeneous set of patterns occurring within a world that is best understood as an unstable complex system (Benatar et al. 2005). Also, globalisation does not, in reality, lead to uniformity, but rather to reconfigurations of labor and human resources, technological capabilities, capital and finances, information and information technology, as well as ideologies and epistemologies (Appadurai 1990). In the context of biomedical research, globalization fundamentally reconfigures the ways in which health and illness are defined, evidence is generated, and interventions are prioritized.

Importantly for bioethics, the processes of globalization are largely driven by those who have the most social, political, scientific and/or economic capital. In the research context, this means that globalization affords translocal networks of researchers the opportunity to adopt or partner with institutions in countries with the most favorable ethical, regulatory and practical benefits that enhance their global competitiveness. While this no doubt facilitates research, it also allows countries that are already dominant in the field to drive the research agenda and financial feasibility of research consortia. It also allows universalistic perspectives to be imposed upon countries that lack the power to resist. In Nepal, for example well-meaning international research partnerships have enabled universalistic biomedical perspectives of psychiatric problems to supersede locally informed conceptualizations of wellbeing in ways that have displaced local buffers against mental illness, obscured the marginalization of vulnerable communities, and perpetuated structural inequalities (Harper 2014:83-102).

Just as powerful nation-states may drive the process and outcomes of globalization, so also may powerful industries, such as the pharmaceutical industry, come to dominate the globalization process. A case in point is the national vitamin A program in Nepal, which aimed to address vitamin A deficiency. In this research consortium, commercial imperatives led to sociopolitical determinants of health being brushed aside, and the project instead being framed in biomedical terms in ways that promoted the financial and ethical capital of the pharmaceutical companies involved (Harper 2014:103-122). This situation is not unique, with other global consortia, such as those focused on type 2 diabetes, similarly influencing the politics of evidence in a manner that favored individual responsibilization and pharmaceutical treatment while drawing attention away from prevention strategies, and discouraging political engagement with the social, historical and economic dimensions of disease (Mendenhall et al. 2016; Yamada et al. 2016). In these ways, translocal health research can play into existing discriminatory modes of power that privilege the wealthy and sustain structural injustice. More specifically, the direct benefits of global health initiatives typically favor groups who may be subordinate but not so subordinate that they are unable to integrate into foreign models of health research. For example, living in a low- or middle-income country may, in theory, qualify someone to participate in a particular research project, but it is mostly those who are well-off and well-educated who are able to participate. If translocal research alliances are to have the breadth of coverage necessary to address global health, then their alliances need to encompass marginalized communities.

The ways in which transnational networks are formed can not only shape their priorities, but also make them difficult to govern as a result of the distribution and compartmentalization of technical, financial and media expertise. While translocal research initiatives may have transnational reach, they do not have supranational power, and individual projects still take place within the framework of nation-states, each with their own legal and regulatory structures. Thus, while researchers participating in translocal networks may be more closely tied to each other than to any particular national allegiances, nation-states still remain the arbiters of how global research consortia distribute, compartmentalize, and deploy their resources and activities. The ethical governance of global health research consortia must, therefore, take into account the sociopolitical history and cultural construction of the nation-states in which projects are implemented, as well as a plurality of knowledge and community values, not only across different nation-states, but also within them.

Global health consortia should arguably aim to supplant these constraining national structures. For unless they do so, their operations are only going to be effectual with respect to their political, academic and social institutional capacity, the collaborative research capacity of the nation-states in which they are embedded, and the ability of societies to "glocalise" (adapt global practices to local conditions; see Robertson 1994) the standards, practices, and funding models of biomedical science. This is a serious limitation because systems of health governance need to not only address the actions of researchers, but also to have sway over the funding models that drive transnational research projects. Countries like Egypt and China, for example, have strict laws about the export of human biological samples, which impacts upon the types of international collaboration that are possible. While this may bolster local biomedical infrastructure for some international research projects, it may compromise the participation

of these countries in global research consortia where funding is tied to particular forms of research and to particular ideas of human tissue.

Governance of global health research also needs to be able to conduct longitudinal monitoring of projects to study and analyze unintended consequences at multiple levels of complexity, and determine if the initiative is reproducing or reinforcing the kinds of structural violence that sustain health inequities. For example, to avoid the harms of epistemological imperialism, ethical governance needs to question the "grobalisation" (international spread of local practices; see Ritzer 2003) of scientific standards, methods and practices. In current practice this means that, in order to achieve the goals of global health justice, research consortia need to be prepared to engage in dialogue with diverse national and subnational agents with plural epistemologies to determine, for example, who is able to participate in, and benefit from, these health research initiatives, and who is excluded.

Unless biomedical research initiatives explicitly address and respond to the challenges raised by globalization, they may simply reproduce existing inequities and fail to gain the trust needed for long-term viability (Lipworth and Kerridge 2015). This is no simple matter for, as we have argued, not only do ethical issues become exponentially more complex when research is globalized, but many new ethical issues emerge. In order to deploy the evaluation of global research consortia checklist assembled by Pratt and Hyder (2016), shared health governance needs to be formed by polycentric coalitions that have a clear process for staging dialogues and alliances between diverse forms of knowledge, dealing with conflicts of interest, engaging with pluralistic community values, and working towards the democratization of bioethics, as well as a sound ability to create distance (processes of separation) between global health research consortia members, sponsors, national organizations and the program staff so that projects are consistent with the goals of the consortia. To move to what Santos et al. (2007:xiv) call an "emancipatory, non-relativistic cosmopolitan ecology of knowledges", marginalized communities need to have representation, leverage, and power in shared health governance, otherwise global research consortia will only end up sustaining global health inequities. Challenging the dominant structures that maintain social inequalities worldwide will require problematizing rhetorical conceptualizations of the global as well as re-invisaging the ecologies of knowledge that are prioritized in global health research governance.

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