

Empowering Communities through University Partnerships in Public Health: A Pilot Project in Nepal and the Philippines

Engaging with the Field: Decolonisation and Indigenisation of Health Education

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Literature Review 2024





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Acknowledgements

'Empowering communities through university partnerships in public health: a pilot project in Nepal and the Philippines' is the title of the University of Sussex's Medical Research Council PHIND project (MR/Y50323X/1), based in CORTH (Centre for Cultures of Reproduction, Technologies and Health) in the School of Global Studies. The 'Empowering Communities' team would like to acknowledge the excellent support provided by Tribhuvan University Research Centre for Educational Innovation and Development (CERID) and the University of Santo Tomas, and all our colleagues at the University of Sussex, particularly: Prof. Maya Unnithan, Prof. Geert De Neve, Mark Raven, Paul Grant, Amy Collyer and Katie Meek. Dr. Anna Magyar provided editorial support and Vermon Bryan Yap Revillosa designed the final reports.



Fig 1: View over the river in Gandaki Province, Nepal. Credit: Sushan Acharya

Engaging with the Field: Decolonisation and Indigenisation of Health Education

Community engagement in public health research has become increasingly 'trendy' and is being embraced by a variety of stakeholders in global health (Page-Reeves and Regiono 2018:2). It is also becoming a requirement of funding bodies (ibid). While disciplines such as nursing, teaching, social work, and anthropology have a long -standing interest in community engagement generally, recent research has focused on the power dynamics within community engagement in public health. In particular, there is concern about how to ensure equitable partnerships and overcome the well-documented barriers to forming partnerships between education and research institutions on the one hand, and communities on the other.

Within academic disciplines that seek community engagement through their research and education goals, there is a recognition of the need for decolonisation. Relationships between universities and communities have not always been equal or respectful. Indigenous communities



have shared frequent examples of negative and exploitative interactions with university researchers (Gittelsohn et al. 2018) and such examples have been criticised for perpetuating colonial violence, racism and extraction (Kelley et al. 2013). Furthermore, the majority of the literature on decolonisation originates in the Global North and therefore has its roots in the perspectives of institutions and scholarship conducted largely from a Global North perspective. There remains a serious need to address trust, sustainability, accountability, cultural appropriateness, equity in findings, equal resources, co-leadership, co-learning, 'powered' contexts and language, intellectual humility, inclusion and shared intellectual authorship (Page-Reeves and Regiono 2018, Gittelsohn et al. 2018). At the same time, recent calls for decolonisation in health and education sometimes miss this critique in the literature, as well as the long-standing conversations about power and structure within institutions and global health partnerships.

The 'Empowering Communities' project aims to address the evidence gap on university-community partnerships in public health. We therefore begin by presenting evidence of partnerships and engagement in education interventions pertaining to health issues (Hall et al. 2015, Narayana and Rao 2019). The literature review explores the approaches that are being taken to develop university and

community partnerships in public health. It acknowledges the long history of critical engagement in pursuit of more equal partnerships, between institutions of health and education, and communities. It also takes into account more recent calls and enthusiasm for specific partnerships in research and education, alongside debates about decolonisation.

This literature review therefore explores:

- *What sort of partnerships have been developed in the past?*
- *How do communities perceive partnerships with universities?*
- *What health practices and knowledge can university partners learn from communities?*
- *How can these models be meaningful and respectfully applied?*

These will be answered in the following sections: University-community partnerships (1) Who accommodates who? (2), Crossing boundaries (3) and Respectful practice (4). The specific purpose of this literature review is to inform the 'Empowering Communities' project. It has therefore been structured with our teams in mind. Each sub-section proposes a further question, with the purpose of guiding discussions within the teams on these aspects, when developing the project activities and analysis.



Fig 2: View of Himalayas in Gandaki province.
Credit: Laura Burke

1. University-Community Partnerships: Overview

It is worth noting that there is a significant gap between the language used around university-community partnerships and what these partnerships look like in practice (Hall et al. 2015). Many disciplines and institutions have made efforts to engage communities in their research. For example, a 2014 survey assessing trends in ‘Community-University Research Partnerships’ received 336 responses from 53 countries (Tremblay 2015). However, there are few successful examples of equitable engagement, and even fewer examples in public health. HerSynthesis Reporte we give an overview of community-university partnerships, with a brief outline of some examples of these relationships in the context of public health. In investigating existing public health literature, a broad definition was needed that would include the keywords used in the literature:

- Community-University Engagement (CUE)
- Service Learning
- Community-Based Research (CBR)
- Engaged Scholarship
- Community University Research Partnerships (CURP)
- Community -University Research Alliances (CURA)
- Knowledge exchange, impact, or translation
- Participatory Action Research (PAR)
- Patient and Public Involvement (PPI)
- Patient Engagement (PE)

For the sake of clarity, the umbrella term university-community partnerships is used here to refer to all of the above. The term encompasses a wide range of methods, activities and models of engagement. In the institutions where the research for this project is based, University of Santo Tomas and Tribhuvan University, the terms ‘Service Learning’ and ‘Patient and Public Involvement/Engagement (PPI/E)’ are used respectively.



University community partnerships involve aspects of community engagement, but to varying degrees and for different agendas. In some cases, the language itself can be a barrier to success. The need for 'plain language' and reducing jargon is seen as central to addressing language power issues (Page-Reeves and Reggiano 2018:4). Dominant western knowledge systems have been accused of 'epistemicide', which is the eradication of excluded knowledge, particularly of those in the Global South (De Sousa Santos 2007). In this regard, Hall et al. (2013) advocate for 'knowledge democracy' when thinking about university-community partnerships, by which they mean recognising multiple knowledge systems and ways of knowing and using it for social action. Key questions for our 'Empowering communities' project to ask then, is who is being epistemically excluded and how can we effectively democratise university community partnerships?

Despite a focus on partnerships and equitability, research partnerships are overwhelmingly initiated and controlled by universities, or outside sources such as governments, industry or research groups (Tremblay 2015). In other words, these partnerships are underpinned by unidirectional research practices. According to Tremblay (2015) there is an ongoing 'contradiction' between the academic commitment to co-constructions of knowledge and community partnerships,

and actual practice. In Tremblay's survey, in the majority of over 336 partnership projects survey, the research did not originate from the community but from the universities. Tremblay attributes this 'apathy'(ibid: 34) in community organisations to a reluctance to partner with a university, due to barriers such as funding, different epistemological approaches, and past negative experiences where there has been an unequal balance in the partnership. There were also imbalances within projects in terms of who participated in the different aspects of the research projects. Community participation was higher in networking and in the framing of research agendas and lower in the administrative funding and data analysis. Academic participation was higher in the design of research questions and methodology - showing an imbalance in the steering of the project (Tremblay 2015: 38).

Our own literature search very much confirmed Tremblay's survey in that we found few examples of university-community partnerships in public health from the Global South. These partnership structures have a relatively long history in settler colonial states such as the US, Canada, South Africa, and Australia (Tremblay 2015). This shows efforts to bridge divides between settler colonial academic institutions and communities. Community engagement itself also appears to be widely supported in higher

education institutions elsewhere, including Netherlands, Palestine, Argentina and Indonesia (Hall et al. 2015). In India, the University Grants Commission rolled out a scheme for fostering community engagement with HEIs. Brazil, Ireland, Jordan, Korea and Uganda also serve as case studies of the high potential of institutionalising community engagement policy (Hall et al. 2015). In the UK, the recent move towards 'Knowledge Exchange' practices, i.e. a non-unidirectional form of research practice, shows that funders are interested in constructing new funding models that encourage community engagement. What remains to be seen is whether 'Knowledge Exchange' will be adopted and implemented in ways that are different from current unidirectional models of engaged research.

Tremblay (2015) suggests that universities, communities and their different 'cultures of knowledge' are using university-community partnerships to achieve different objectives. The goals for universities are student training, the co-creation of new knowledge, knowledge management and problem solving. While the co-creation of new knowledge is also a goal for communities, these partnerships are also expected to deliver capacity building, social change and support for community services.

The practise of healthcare within communities has long been part of health education. Community-based education, in which health students complete part of their studies in health facilities that are located within local communities, is a popular form of education.

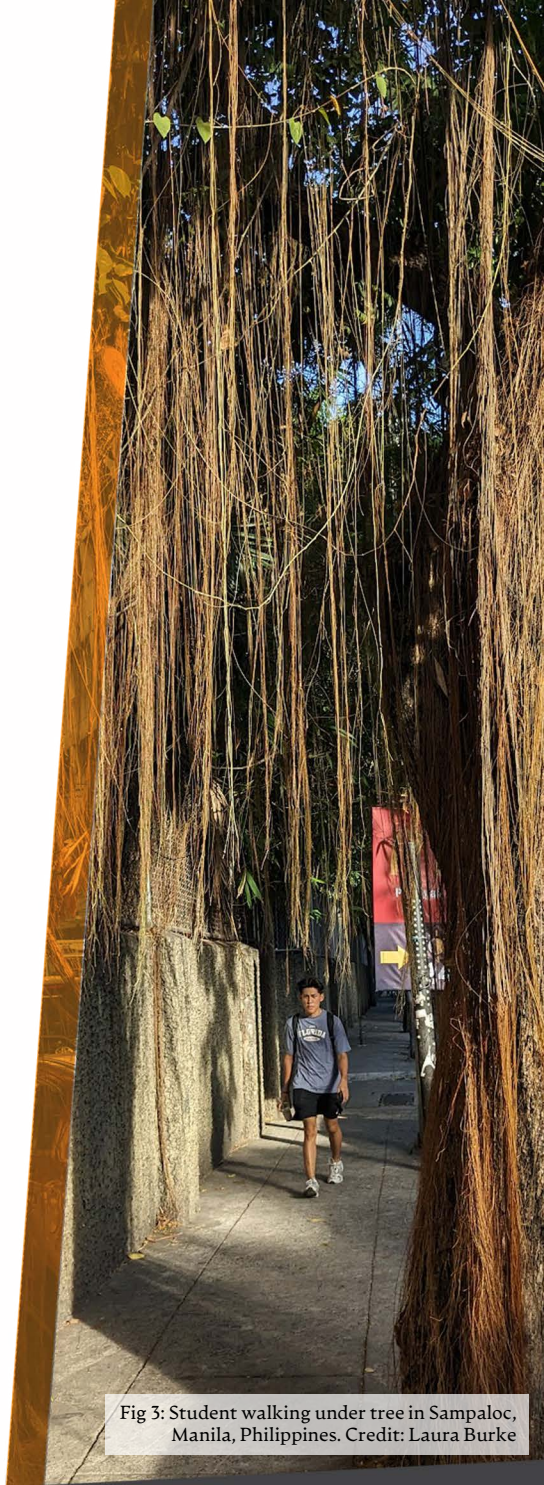


Fig 3: Student walking under tree in Sampaloc, Manila, Philippines. Credit: Laura Burke



In this regard, the need for more engaged or equitable partnerships between universities and communities for improved health outcomes, is clear. In the context of education and nursing practice, the notion of the ‘community as partner’ has played a role in a shared commitment to the population (Anderson and McFarlane 1996).

An example of higher education engaging with communities for better health outcomes is given in the book *University-Community Engagement in the Asia Pacific: Public Benefits Beyond Individual Degrees* (Collins 2017). One case study from Taiwan describes the Active Ageing learning centres that have been established as a university response to an ageing population. Rather than traditional academic courses, these centres offer learning courses that provide social benefits through taught learning programmes. Other examples in the book involve tourism, transnational education and cultural preservation rather than health, but they demonstrate that community engagement is possible. While there is support for health partnerships in the Asia Pacific region, examples are few. One assessment of community-based courses at Tribhuvan Institute of Medicine in Nepal (Choulagai, 2019), found that while such courses were effective for individuals, there was a need to fully engage communities in the planning implementation and evolution of community-based education.

Examples of successful university-community partnerships in public health are even fewer, with most located in settler-colonial states. In Canada, Duignan et al. (2020) explored ways to co-construct a survey on water usage and Indigenous knowledge. In order to engage communities in collecting and directing the collection of health data, the survey became a ‘boundary object’, in that it brought two groups together. Part of community-based practice research methods, the survey as boundary object facilitated deep discussion, and helped to produce a survey that was useful to both the community and policymakers. After several rounds of reflection during the creation of the survey, community health needs and priorities around water and contamination were identified. This was envisioned to be a long-term project in which the community could also use and update the survey for their own advocacy needs. The collaboration fostered by this ‘boundary work’, the authors argue, develops long-term trust and partnerships (Duignan et al. 2020).

A collaboration between local residents, an NGO and HE institutions, is examined in a study by Corburn and Karanja (2016). Here the residents of the Mathares, informal settlements in Nairobi, collaborated with local organisations to co-produce insights rich in relational and context-specific data. The authors state that participatory approaches in public health

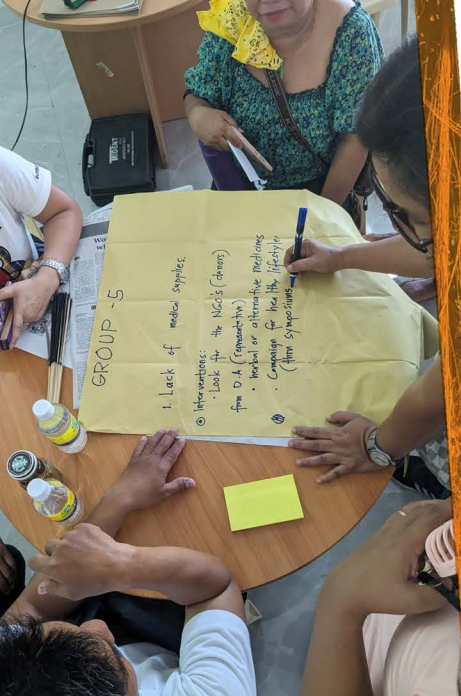


Fig 4: A health worker participating in a community engagement workshop in Calasiao, Pangasinan, Philippines. Credit: Laura Burke

are 'essential for generating accurate data for healthy informal settlement planning and development, yet residents too often are ignored or seen as passive recipients in urban public health and planning initiatives' (Corburn and Karanja 2016:267). In this case, a local NGO (Muungano) invited the University of Nairobi and the University of California (Berkeley) to support the planning process, data gathering and analysis, in a project to document and map the health of the slum settlement. Data gathered over three years included a household survey and spatial mapping data, gathered by residents and the NGO, where village structures and sanitation were mapped. The survey and mapping data were reviewed, discussed and validated with residents. The university researchers were both participants and observers in the process, while the NGO facilitated the community planning meetings and focus groups. A relational approach to health requires an understanding of history and lived experiences and residents' local knowledge. The findings in relation to toilet infrastructure, for example, led to residents, NGO and academics co-drafting an infrastructure upgrading plan for four villages. A proposal was then sent to local water companies for piped water services. Lastly there was a draft for an upgrading plan for the entire slum settlement, the first such plan for the city of Nairobi. In addition, the World Bank is using this plan to build new sanitation infrastructure (Corburn and Karanja 2016). The study shows how the collaborative process between residents of Mathares' informal settlements and the universities, resulted in co-produced

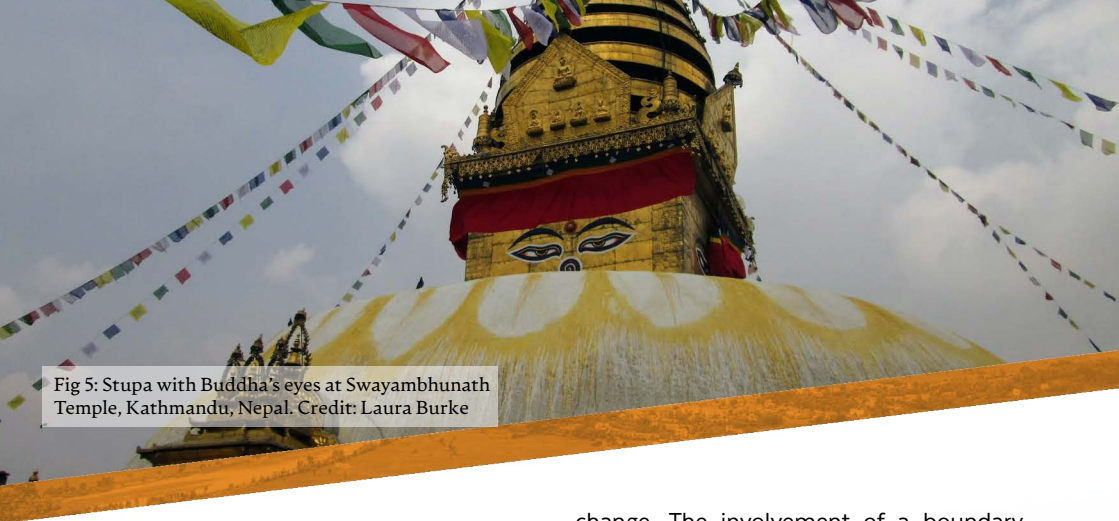


Fig 5: Stupa with Buddha's eyes at Swayambhunath Temple, Kathmandu, Nepal. Credit: Laura Burke

insights, along with relational and context-specific data, that led to real-world action. In this case, the role of collaboration of the universities and the NGO with the local residents enabled residents' voices to be heard by the local government, water companies and international NGOs. These co-produced formal proposals for change were taken on board and the outputs of the project are being used to inform future ones.

However, Perkins (2019) warns that collaborative activities that create space for local voices, as opposed to top-down or expert forms of knowledge, are not always effective. Whilst boundary objects may be useful for collaboration, there is a concern that methods such as surveys, questionnaires and map making, which are often tools in global health engagement, originate from colonial and state building activities. In addition, they are likely to be most relevant to the public health professionals rather than the local population. In such examples it is not always clear how the collaboration on a product translates into long term engagement or

change. The involvement of a boundary object in the form of a map or survey risks imposing western values on communities and recreating colonial infrastructures of health (Robinson-Pant 1996, Murphy 2018,). In addition, such methods and tools are more familiar to universities and biomedicine. Perkins (2019) suggests that accountability, transparency and ethical considerations can go some way towards mitigating these risks.

Through a biomedical lens, health, including public health, is often conceptualised as individual, static and biological, with culture and society seen as more superficial factors. Bioethnography has been proposed as a form of research that is not underpinned by a division between biology and culture (Roberts 2021). Instead, in a bioethnographic approach, ethnographic engagement and collaboration are used from the outset to explore the relational and situated dynamics of health. The aim is to co-create health research and the questions it seeks to answer, from the very beginning, rather than as an edition to survey data. Rather than working from a hypothesis, open-ended interactions



and observations help to ask better types of research questions, thereby contributing to the collection of multiple types of health data. Roberts argues that bioethnography can be seen as ‘big data’, creating better knowledge and better numbers for policy makers. However, as a method, it relies on committed, long-term engagement with communities, and engagement across the health sciences. Such reciprocal engagement involves not only the building of trusting and respectful relationships but also the consideration of epistemic justice (Dilger et al. 2015).

In cases of collaboration, whose methods, ways of knowing, and tools are being centred?

2. Who accomodates who?

One of the aims of this project is to find out how communities perceive university-community partnerships. What are the community’s concerns about engaged research? What sort of accommodations are made by and for the different partners and the demographic groups amongst them? Given the nature of academic research, few community voices come through in academic writing about community-university partnerships. As such, many of the barriers and recommendations for

building successful partnerships are largely generalised and centre around un-doing unequal relationships, rather than specific examples of relationships, projects or collaborations.

In one study, the authors (Gittelsohn et al. 2018) focused on the need for ‘building capacity’ in community-university partnerships to improve health and wellness and reduce disparities. Their recommendations draw on the experiences of university researchers rather than the experiences or perspectives of the communities themselves. The recommendations encompass many of the characteristics that have already been mentioned, such as the need for respectful and supportive relationships, the need to reduce discrimination, develop sensitive policies and practices, and use of appropriate methods and practices. Similar recommendations are listed in Page-Reeves and Regino (2018) who investigate community-university health research partnerships from an anthropological perspective. They also offer some more concrete guidance such the importance of acknowledging expertise, co-learning and power inequalities, shared authorship, equitable discretion of resources, and long-term commitment. Reference is also made to the language used in terms of reducing jargon, using ‘plain language’ and paying attention to cultural appropriateness.

A key component of the community partnership model is 'readiness' (Bourgeois and Palmer 2022). Historically, this has referred to the capacity or the need for capacity building within the community, so that they are prepared to take part. In other words, the general assumption is that the university is always prepared and ready to work with communities. Bourgeois and Palmer argue that we need to reverse this assumption, given that universities are not often able to accommodate community partnerships in a meaningful and respectful way. They argue that universities need to conduct internal readiness assessments. This would include being 'ready to welcome and facilitate authentic engagements' as defined by the community (2022:15). In the context of Bourgeois and Palmer's research on the repatriation of indigenous objects for example, they specifically highlight the

need for universities to be more flexible, understanding and open to community choices. This need for institutional flexibility and community choice is also apparent in the procedural ethics review processes at universities in which local context, need, or voices are ignored in favour of standardised process. For example, medical ethics forms do not always accommodate qualitative research methodologies, particularly PAR or ethnography, nor do they make space for ethical commitments made to communities in local contexts.

When working in partnership with communities, there is a need for mutual learning around ethics, to uncover how shared values might be conceptualised or emphasised differently. A literature



Fig 6: Mapping the 'Department of Health' at a participatory action research workshop. Credit: Laura Burke



review of global health ethics and aboriginal research ethics, for example, found that whilst there were some shared concepts, aboriginal research ethics gave more emphasis to community agency, ownership and control (Harper and Pratt, 2022). A useful distinction that has been made is that of procedural ethics, pertaining to an institution, versus ‘ethics in practice’(Guillemin and Gillam 2004) or situated ethics (Simons and Usher 2000).

An example of a successful partnership is a university-community health partnership in Utah, USA, based on the ‘Community Faces Model’(Drits-Esser et al. 2019). The Community Faces of Utah (CFU) comprises organisations that represent five ethnic communities, an academic university medical centre and a state health department. Community liaisons were central in facilitation and collaboration. Over time, the group was able to build a functioning community health coalition. Whilst trust, genuine collaboration and commitment to equity were important elements, recruitment of respected members of the community for community liaison and skilled facilitation were found to be of key importance by all involved. The overriding measure of success was that each community partner reported that they had benefited from the collaboration. They gained both personal and professional growth and felt that the collaboration had enabled them to accomplish goals as a

group that they could not achieve alone. The CFU coalition **format**, where more than two groups are involved, and the multi-sectoral approach differs from direct partnerships between one university and one or several communities, by having multiple partners. Perhaps this has the effect of diluting strained power dynamics. The question remains, however, whether this coalition approach adds more complexity and therefore more barriers, or whether it is effective at levelling the playing field, by having more players who are at the same level. In this sense, it becomes a case of accommodating all, rather than who accommodates who.

Times of crisis might be a point at which institutions are willing to make more accommodations to serve the public, which may serve as a starting point for more sustainable collaborations. One such project emerged during the SARs pandemic (Yuen-Tsang and Tsien-Wong 2004). Before the SARs outbreak, the Faculty of Health and Social Sciences at the Hong Kong Polytechnic University (PolyU) ran community health education programmes. However, during the pandemic the staff and students opened hotlines for patients, medical staff and children, support calls for the elderly and collected messages of appreciation and gratitude from the public to doctors. The project included consultations and training for teachers and parents, and research. The project was



Fig 7: Buenlag Health Centre in Pangasinan, Philippines . Credit: Laura Burke

driven by a sense of civic responsibility in a crisis, and everyone worked as volunteers. The project ended when it was no longer needed but post project, interviews with volunteers showed how the project had reduced stress amongst those involved, and strengthened staff-student relationships, reducing academic power hierarchies, as well as the distance between community partners and universities (ibid).

What does it take for institutions to be 'ready' to partner with communities? What accommodations should be made and by whom? What ethical frictions need to be overcome?

3. Crossing Boundaries

The discussion of the 'global' in public health goes far beyond cross border health issues and joins the local to the global. In the colonial-era, 'tropical medicine' dealt with medicine that was practiced in colonised territories and was designed to uphold colonialism rather than treat health issues in general (Hirsch 2020). This transformed into 'international health' in the post-war area, eventually becoming 'global health' or even 'global public health'. The 'global' in global health has its ties to health inequalities and interventions by international organisations (Biehl 2016). Predominant understandings of global health today include the recognition of the hegemonic position of the Global North (Holst 2020). Biehl (2016) argues that the



‘global’ in global public health should be a reminder of what Stoler calls ‘imperial durabilities’ (2016), that is, the colonial histories that remain active forces in our world today.

As the previous sections have outlined, university-community partnerships require multiple boundaries to be crossed: sectoral, geographical, epistemological, methodological as well as boundaries of trust. The renewed attention to decolonisation in public discourse has led to revisiting some of the boundaries and barriers to challenging the persistent power dynamics in public health at different macro (international) and micro (community) levels.

Discussions about decolonisation in health and education, largely taking place in academia and the Global North, were re-inspired and invigorated by the global pandemic and the Black Lives Matter movement. Since 1995, when Linda Tuhiwai Smith wrote that research was one of the ‘dirtiest words’ in the vocabulary of Indigenous peoples, there have been significant changes in their agendas, alongside indications of positive change (Smith 2021). However, despite the shift in discourse towards promises of diversity and inclusion, ‘no real progress has been made to decolonise the major knowledge and political institutions of academia’ (Smith 2021: xii). Furthermore,

in terms of the aim to decolonise global health, an ideal implementation process remains ill-defined (Kulesa and Brantuo 2021). Exploring the entanglement of education, health and colonialism, the authors identify the barriers that arise when trying to decolonise educational global health partnerships. These include: an overemphasis on international partners rather than local ones; implicit hierarchies; and ethical dilemmas which prioritise biomedicine. Kulesa and Barantuo find that due to hierarchies which prioritise higher income countries, global health education partnerships perpetuate colonial legacies which limit health access and contribute to poor outcomes. Whilst a common strategy is to shift power to local owners, there are few clear plans on how to make this a reality (Mogaka et al. 2021). Some argue that it should be local leaders who lead global health research, with foreign academics providing support rather than the other way round. Others call for radical transformation to undo white supremacy within global health institutions (*ibid*), or for equitable economic ownership of global wealth (Kwete et al. 2022).

What is clear is that decolonization requires examining socioeconomic and political contexts (Mogaka et al. 2021). For example, global health partners can struggle to include and represent local groups affected by their work, causing inequalities (Kulesa and Brantuo 2021). Implicit hierarchies

underpin the so-called ‘nervous-conditions’ of inequality, with practitioners from high income countries and backgrounds assuming the role of educators (ibid). Kulesa and Brantuo (2021) advise that to mitigate the power imbalances, these practitioners must become more immersed in the communities, taking time to learn about them. Incompatibilities between foreign and local partners and different agendas, remain central issues that can only be addressed through establishing close communication between the two groups. Lastly, Kulesa and Brantuo (2021) suggest that local partnerships should promote ‘positive defiance’ by discussing local, contextual health practices and cultivate ‘cultural safety’, which involves predicting the overall impact of their work on the communities, including power imbalances. Elsewhere Binagwaho et al. (2022) have argued that while the term ‘decolonisation’ has been used to refer to eliminating colonial legacies in global health, the term can mask the root of the problem, which is in fact racism and white supremacy. The authors therefore call for the elimination of white supremacy instead, and the need to equip students with the tools to critically analyse, question and create new kinds of partnerships, ones that are mutually beneficial and equitable.

Whilst research collaborations between institutions in the Global North and Global South have promised to disrupt the hegemony of the Global North, in practice they are ridden with tension and failure. Based on this view, “South-South” interactions and collaborations, that is, relationships between educators and



Fig 8: Christmas tree made from empty medicine boxes in a Health Centre in Sampaloc, Manila, Philippines



Fig 9: A small Catholic chapel in Manila, Philippines
Credits: UST Team, Philippines



researchers in the Global South, have been positively anticipated as pathways to a positive, collaborative, decolonial academic future (Roy 2023). However, as Srila Roy (2023) points out, collaborations amongst southern scholars and institutions are not free of power imbalances and local hierarchies. These in turn affect the inequalities and asymmetries that run through global knowledge production.

Coloniality of knowledge and power manifests differently in different global south contexts. The theories that global south scholars engage with and challenge, or colonialist roots of many academic disciplines, impact the degree to which knowledge production can be seen as decolonised. This can lead to a failure in creating a shared ground with Global South partners, or 'dissonant intimacies' (Roy 2023). Furthermore, the desire for South-South symmetry and intimacy, can obscure existing frictions and hierarchies. For example, research collaborations often emanate from, or are closely aligned with, neoliberal universities, with their own agendas and assumptions, Roy argues. This means there is little space for collaborations to develop organically. At the same time, without the involvement of the Global North, there is also a lack of material funding. In light of the power structures that universities are embedded in, Roy (2023) suggests that bottom-up forms of organising and social movements, such as student activism in the case of

higher education, might be an alternative to top-down attempts to decolonise through South-South partnerships. This is a reminder of the need to think more intersectionally across institutions but also within communities. Rather than treating 'community', or 'university' for that matter, as a homogenous entity in community-university partnerships, the question that needs to be asked is what intersecting inequalities and identities are within? Do any already cross boundaries? In addition, we might think about how we shift power at a micro-level between universities and communities as a local level, rather than only looking from the macro perspectives of the Global north and Global south.

The UN University has begun working on 'shifting power in global health', which involves decolonising discourses, including challenging the global rankings of universities, and the outputs of global health academy in writing, publishing, as well as rankings of think tanks and aid. This 'power shifting' is much needed to create more equitable partnerships. However, so far, it challenges only the academic community. Perhaps more community-level efforts, and bottom-up initiatives, as Roy suggests, need to be encouraged.

Should universities be more immersed in communities?

How can we cultivate more bottom-up approaches without reproducing power hierarchies?

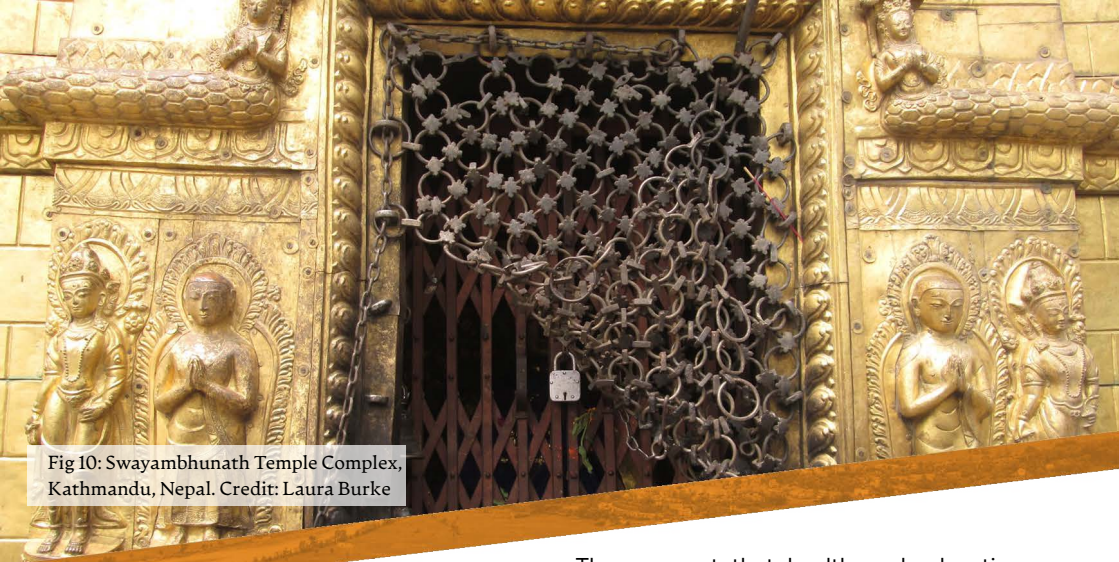


Fig 10: Swayambhunath Temple Complex, Kathmandu, Nepal. Credit: Laura Burke

4. Respectful Practice?

This last section begins with a series of questions. Given the lack of examples of successful university-community partnerships in public health, how might we conceive of sustainable, respectful partnerships between universities and communities? What language can bring together the disparate literature and frameworks that currently exist? What do institutions need to change in order to engage in better partnerships? How can multiple boundaries of knowledge and power be crossed and maintained?

According to Acharya and Robison-Pant (2019), social transformation comes about ‘when people become ‘co-creators’ of knowledge, learning from peers and choosing how and when to engage with different literacy and health practices.

They suggest that health and education practitioners need to look at the more complex picture of changing social, political and environmental domains that exist outside planned health and education interventions. Informal learning, and exploration of different forms of learning that people engage with outside of planned programmes, is an essential first step to developing more socially just programmes (ibid).

One exception to the dearth of successful examples is a public health partnership involving a Global North institution (University of California Los Angeles) and a Global South institution (University of Philippines). The aim was the prevention of non-communicable disease, and care through primary health services in the Philippines. Improved health outcomes were the end goal, alongside continual innovation, sustained programme activities and host country ownership. The focus was explicitly on developing an equitable partnership to build research capacity and produce data for policy (Aryal et al. 2023).



As in other projects, factors such as goal setting, cultural bridging, collaboration between teams and capacity building, are mentioned as ways to build strong connections, in this case not between the community and university but between a higher income country's institution and a lower middle income country's institution. Where the project differs is in its emphasis on power shifting at the outset, for long-term mutually beneficial partnerships.

The University of the Philippines (UP) initiated the partnership, which can be seen as a reversal of the usual direction. Also, in contrast to other partnerships, funding for the project was identified from the host country's funding opportunities (albeit one that specifically focuses on funding for institutions in the Philippines and California). In order to collect local data and extend their capacity building outside of Manila, the host university built relationships with other local universities. All members of the University of California Los Angeles (UCLA) had ties and familiarity with the Philippines, as well as diaspora communities in the US. Members of the UP also had 'exposure' to US academic culture, with two having doctoral degrees from Californian universities. Exchange visits were also set up. Ultimately, the project was led by UP, with UCLA playing a consulting role. In terms of data collection for the project, the teams sought to adapt a Primary Care Assessment Tool (John

Hopkins) to the local context. Ayrál et al. (2023) report that this project helped to build a stronger connection between institutions, such as mutual goal setting, cultural bridging, collaborative teams and capacity building. In terms of power structures, this example shows some reversal of the usual power dynamics and a commitment to power shifting in global health research. The model suggests a new directionality and opportunities for challenging the hegemony of the Global North. However, when it comes to public healthcare, there is little discussion about knowledge, indigenous or local. It is also unclear how research tools originating in the US were adapted to the local context.

Another case in the Philippines involved a mix-method longitudinal study on non-communicable diseases that featured a collaborative aspect (Mendoza et al. 2021). Together with the London School of Tropical Hygiene and Medicine and UP, the research involved hypertensive adults keeping and submitting digital diaries over a period of 12 months. However, they found that their elderly and low-income participants were not comfortable with the medium and as hypertension can be asymptomatic, they found it difficult to collect in-depth narratives. The authors point out that with extensive co-production, particularly to understand participants preferences, collaborative methods could be useful for investigating chronic illness.

What are the opportunities & challenges presented by university & higher education institutions in terms of health nutrition literacy?

Community feels seen and heard

CHALLENGES

- LIMITED RESOURCES - money, transport, access, readability
- Varying Educational Attainment Levels
- NOT APPROPRIATE LSA
- REQUIREMENTS OF TEACHING/LEARNING TO BE RELEVANT
- REQUIREMENTS OF THE COMMUNITY
- Lack of support from the community
- DIFFERENT LEVELS OF UNDERSTANDING AND ACCEPTANCE
- DIFFERENT GOVERNANCE CONCERNS OF THE COMMUNITY
- Language barrier
- Political views / Lack of funding for research
- UNABLE TO ENGAGE SUPPORT
- Maintaining effective partnerships with both of their having different priorities
- Not a priority
- possible barrier for research/ practice TAKE NOTES
- Sustainability?

Knowledge + PROGRAMS

- MAINTAINANCE
- EMPOWERING THE COMMUNITY
- VERY APPROPRIATE LSA
- GOVERNANCE OF POLICY/ PROGRAMS
- THE INSTITUTION

Resourcefulness

- Linkages & Networking
- Lower access to infrastructure
- access to other kinds of knowledge
- Special skills/ expertise
- social media

Finding or creating a Common Language

- Additional expertise in different roles
- desires to be able to practice medicine

What more can community partners and university partners learn from each other in terms of public health efforts?

community

INTEREST PARTICIPATION

WILDERNESS CHANGE IN INTEREST

EMPOWERMENT

EXPERIENCES CULTURE PRACTICES INNOVATION

EXPERIENCES CULTURE PRACTICES INNOVATION

SUSTAINABILITY

noted by CST 100% agreed!

What more can community partners and university partners learn from each other in terms of public health efforts?

Communication

community & university partners

from each other - questions about the partnership process - patient setup and how the other member's existing programs and resolve such challenges improve public health efforts

NEW

RELEASABLE

TIME

NEW

Fig 11: Poster from a workshop on University-Community Partnership reads: "What more can community partners and university partners learn from each other in terms of public health efforts"

In the examples above from the Philippines, the studies show innovation in collaborative partnerships between universities and communities. However, it is clear that it remains a challenge to tackle all barriers at the same time. The question remains as to what innovative methods can be used to cross multiple boundaries (University-Community, Global North-South, Urban-Rural, Indigenous health-biomedicine) simultaneously?

Despite what has been stated about decolonisation in discourse, many argue that 'decolonised' perspectives have not gained sufficient traction in global health education and knowledge production (see for example, Eichbaum et al. 2021). Unequal and inequitable power dynamics, alongside neo-colonialist assumptions, continue to dominate. To shift old colonial paradigms, the authors argue, there is a need for more inclusive and transformative learning approaches, as well as more critical reflection and concomitant action. The lack of access to certain types of literature in lower middle- income countries in the discipline of bioethics, for example, in make it virtually impossible for scholars in those countries to contribute to the bioethics global body of knowledge. This leads to the underrepresentation of certain contextual and ethical perspectives (ibid). Similarly, inequalities such as access to funding, inability to take extended time away from home, hinder access to certain types of cross-cultural or field training. There have also been calls for more 'meaningful engagement' in medical practice, such as extended learning experiences that are multi-directional (Garba et al. 2021).

Other critics of what has been referred to as the ‘decolonising turn’ in global health, have argued that colonial ontologies continue to be embedded in a great deal of global health (Hindmarch and Hillier 2020). These ontologies exclude indigenous ontologies which could change how global health is thought about and practised. Within this debate is the obvious politically loaded challenge of categorising what counts as ‘indigenous’. Within our country contexts alone there are varying understandings of what is considered ‘indigenous’ and these are undoubtedly disputed by groups who are either included or excluded from that category. Hindmarch and Hillier argue that the universal, fact seeking, neutralised values of current global health reflect Western conceptions and epistemologies. Therefore, in rethinking global health, decolonising or ‘indigenous’ health

knowledge is needed alongside political actions to bring about structural change. Such actions will only be effective if there is a willingness to engage with the ontological foundations of global health, and the Western assumptions about health itself. Once these assumptions are deconstructed, global health must then be reconstructed with the help of indigenous ontologies, for ‘a new global health imaginary’ (Hindmarch and Hillier 2020: 2). In short, we need to change the way we think about health and the structures within which we practice global health.

The literature, in particular, Hindmarch and Hillier (2020) and Aryal et al. (2023), suggest two important objectives for university community partnerships:



Fig 12: Rice Terraces in Gandaki Province, Nepal.
Credit: Laura Burke



changing the structural inequalities (such as funding, roles, approach etc) within partnerships and reversing or making more equitable the structural power hierarchies, alongside ontological deconstruction and reconstruction and epistemic power shifting. Neither are small projects, and it is clear that we need more models that can help to achieve such objectives.

Are role reversals possible? Where can we shift power? How can collaborations begin to reconstruct ontological differences?

What examples can we provide from our own experience to answer the questions arising from the literature?

This literature review has explored the existing literature concerning university community partnerships in public health. Critical engagement with this literature has led to some more focused and targeted questions that guided our research activities and analysis. It is clear that university-community partnerships have been tried and tested in different contexts, but often fall short on aspects of partnership that fail to deconstruct existing power imbalances and challenge dominant epistemologies and ontologies. Whilst there are examples and projects which provide useful insights into how partnerships can be more equitable, both at a local and global scale, there is clearly no blueprint for public health partnerships.

Such partnerships require at the very least, deep contextual understanding and awareness of historical inequalities. This review has, however, posed some focused questions for our teams, to be used as a tool for critical analysis and reflection on the partnerships that are forming as part of this project.

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