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Unequal ecosystems of global health authorial expertise: Decolonising noncommunicable disease

Abstract

The decolonisation agenda is gathering momentum in global health. Within this movement, one domain of analysis has been the ways in which the geographies of *scholarly* knowledge production (re)produce the inequities of coloniality. Drawing on the example of noncommunicable diseases (NCDs), here we deviate from this and instead examine the authorship of the *key global documents* that were used to ignite and mobilise the NCD advocacy agenda from 2000-2020. In doing so, we reflect on the changing ecosystems of authorial expertise. It shows that while the geographic distribution of expertise has broadened over time, the NCD domain remains a fairly tight and circumscribed network. Importantly this research also shows the complexities of ascribing location to expertise, a finding that speaks back to the decolonisation debate.

Introduction

Within global health, questions are increasingly being asked about cultures of scholarly research publication and authorship (Abimbola 2019, Nafade, Sen and Pai 2019). This is part of a far broader set of debates and concerns around the extent to which global health is ‘neo-colonialist’ (Horton 2013) and thus part of a machinery of ‘coloniality’ (Quijano 2000, Richardson 2020) that should be ‘decolonised’ (Büyüm et al. 2020, Affun-Adegbulu and Adegbulu 2020). The decolonisation movement has a long provenance within the humanities and social sciences, but it has been slower to gain traction within global health’s biomedical and public health circles. Global health’s complex architecture – across funders, philanthropies, NGOs, universities, national governments, international organisations and the private sector – and its competing priorities, methods, epistemological and disciplinary underpinnings, mean that its very essence can be hard to pin down. This is perhaps inevitable given that even within one university, those working on global health may have fundamentally different views about *what* and *where* it is depending on their disciplinary positionality. Yet, broader attention is

nevertheless starting to turn to the ‘lack of diversity in global health organisations, [and] the power asymmetry that is all pervasive in global health’ (Pai 2021). This, in turn, is producing new avenues of research and critique within the field. These, in turn, speak to broader debates about the power structures inherent within ‘circuits’ (Collyer 2018) of scholarly knowledge production (Guédon 2008), and questions of ‘centre-periphery’ relations (Connell et al. 2017) and the ‘dynamics of change’ within the ‘global economy of knowledge’ (Connell et al. 2018).

With this context in mind, this paper draws on one small corner of the global health world – noncommunicable diseases (NCDs) - to explore a particular problematic within the decolonisation lexicon: the geographical distribution of authorial expertise and, therefore, the construction and circulation of “credible” knowledge production and consumption (Bhakuni and Abimbola 2021). This, it should be noted, is not the same as expertise alone, but should rather be understood as a status conferred on those experts invited to author significant international position and policy papers that have been used to advance the global NCD agenda. NCDs offer an interesting and underexplored example through which to approach these questions. In the first instance, the category is something of a global health paradox: its constituent diseases account for over 71% of global deaths (85% of which are in Low and Middle Income Countries [LMICs]) according to the World Health Organisation (WHO), but the category itself accounts for less than 2% of all global health funding (Nugent 2016). This gross disjuncture between need and resourcing has attracted substantial critical analysis (Adjaye-Gbewonyo and Vaughan 2019, Herrick 2019, Bukhman et al. 2020).

The lack of funding, however, belies significant efforts to push the NCD agenda right to the top of the United Nations General Assembly. This endeavour was made possible by a tranche of key documents, emerging mainly from the World Health Organization (WHO), to a lesser extent the World Bank, and through a number of *Lancet* series over two decades. While a portion of these have been subject to critical analysis to uncover the origins of the particular

formulation of the NCD category used by WHO and others (Schwartz, Shaffer and Bukhman 2021, Weisz, Vignola-Gagné and Review 2015), the significance of *who* wrote them and from *where* has garnered less attention. This paper therefore brings together two debates within global health - on authorship and the endeavour's geographical asymmetries – that, together, emerge from and directly feed into the decolonisation agenda. Drawing on bibliographic analysis and data mapping, it argues that the topography of global health can be understood as one of unequal ecosystems of authorial expertise.

The NCD global health agenda

Building on the expository work of the World Bank's 1993 *World Development Report* which, for the first time, revealed the scale of the burden of disease from NCDs in the global south, advocates at the WHO and beyond sought to highlight the centrality of health to economic development (Sachs 2002). The publication of the WHO's *Global Strategy on the Prevention and Control of Non-Communicable Disease* in 2000, led by Dr Ala Alwan, then Director of the Department of NCD Management represented a strategic moment in this regard. As it highlighted,

The rapid rise of noncommunicable diseases represents one of the major health challenges to global development in the coming century. This growing challenge threatens economic and social development as well as the lives and health of millions of people... LMICs suffer the greatest impact of noncommunicable diseases.

The repositioning of NCDs from an inevitable outcome of unhealthy lifestyles in the global north, to a manifestation of and contributor to inequality, poverty and social injustice in the global south represented a turning point in how the disease category was positioned within global health (Schwartz et al. 2021).

What followed was two decades of intense advocacy work to ensure that NCDs were included in the Sustainable Development Goals (SDGs) and, moreover, to gather member state support

and funding for their ‘prevention and control’. However, after the significant win conferred by the inclusion of NCDs in SDG 3.4, the pace of political progress at the UN arguably ran up against resistance, a lack of accountability mechanisms and funding gaps (NCD Alliance 2018). So much so, that a post-UN HLM report by the WHO declared it ‘time to deliver’ and another argued that now was the time to ‘walk the talk’ (World Health Organisation 2018, 2019). The period from 2000 to 2020, before the novel coronavirus turned global health on its head, was arguably the most energetic in driving forward the NCD cause. That path was lubricated through a significant volume of academic publications arguing the case for NCDs, including four commissioned series on NCDs in *The Lancet* in 2005, 2007, 2010, 2013 and a Taskforce report in 2018. From 2000 onwards, the WHO produced no less than 39 significant reports, action plans, policy papers, strategies or frameworks about the *global* issue of NCDs, with multitudes more focusing on issues particular to a regional or national scale. The World Bank’s 2011 report *The Growing Danger of Noncommunicable Disease* was also an important document that actively fed into the UN HLM process. Together, this compendium of documents illustrates not only the evolution of the arguments put forward for NCDs in the global health sphere, but also, when taken at a human level, the spatial and social configuration of networks of authorial expertise within the field.

Global health authorship – the case of NCDs

Debates on academic authorship within global health journals are very live, especially in the context of collaborative or “partnership” research arrangements between high income (HIC) and LMIC institutions (Hedt-Gauthier et al. 2019, Mbaye et al. 2019a, Crane 2020). These conversations have, for example, sparked some commitment to diversity on editorial boards (Bhaumik and Jagnoor 2019, Clark and Horton 2019) and ignited long overdue reflections on the distribution of power, and the political and ethical challenges of representation in global

health (Karkey and Green 2018). For many outside global health – especially for scholars in anthropology and allied social sciences – questions of representation, who can legitimately and authentically ‘speak for’ whom and the ‘contested positionality’ of many ‘Southern scholars’ are longstanding (see Yamashita, Bosco and Eades 2005). Returning to global health, amid the attention to the vastly uneven global economy of *academic* publishing, less attention has been paid to the somewhat quieter domain of what we term ‘authorial expertise’: who advises on and authors the major reports, strategies, journal series or policy papers that are often instrumental tools in driving forward particular global health agendas. These arguably occupy a different niche within the global health publication ecosystem - reliant on academic research but filtered through multiple political frames in order to animate and stimulate debate, bolster advocacy, communicate need and, ultimately, drive shifts in prioritisation and funding flows. Authors often emerge *because* of their existing expertise, but also because of their position, connections and convening power. Some may be permanent staff at the WHO or World Bank or United Nations, while others may be academics, leads at NGOs or directors of medical and public health associations who are “credible” and well-placed to drive change.

Bibliometric research on global health authorship has tended to either focus on the field in general (Dimitris, Gittings and King 2021, Iyer 2018) or for infectious disease (Mbaye et al. 2019b, Hedt-Gauthier et al. 2019). In the case of the former, Dimitris *et al* (2021) have noted that while the absolute number of publications *written about* LMICs has increased roughly five-fold from 2000-2015, the proportion of publications with first or last authors from LMICs has remained far more static over time and, in 2017, stood at 77% and 71% respectively. Their paper shows that while 86% of publications had at least one LMIC author, there was a big gap between representation from middle income and low-income countries that can be obscured by the LMIC/HIC or global South/ North frame of comparison. Iyer (2018) also highlights this disparity in her finding that for papers about Africa published in the *Lancet Global Health*

between 2013-2017, only 44% had LMIC authorship. In the context of infectious disease research, however, the picture is somewhat different. For example, Mbaye *et al* (2019b) find that 93% of the papers about infectious disease in Africa that they reviewed had African authors. However, and perhaps most importantly, African authors occupied coveted first and last positions in less than half of these papers. This inequity in authorship position is echoed by Hedt-Gauthier *et al* (2019) who find that for papers about health in Africa, the overall representation of local authors (as well as those in first and last place) fell when co-authors were from the USA, Canada or Europe. These studies have thus fed into calls for more equitable and inclusive partnerships and collaborations between researchers across low, middle and high-income countries (Eichbaum *et al.* 2021).

It is notable that NCDs have been largely absent from the specificities of this debate, although are considered by Weisz *et al* (2017) in their network analysis of global health publications. In the first instance, their paper is instructive for the arguments we make here in that it highlights the overwhelming dominance of the *Lancet* as a global health publication outlet and the high frequency of WHO-affiliated authors in the field. In keeping with Plancikova *et al's* (2021) analysis of public health publications in which they find 84% of authors to be based in High-Income Countries, Weisz *et al* (2017) similarly note the dominance of authors from particular institutions in the UK (e.g. University of London and the London School of Hygiene and Tropical Medicine) and the United States (e.g. Harvard and the University of California). In second place, their paper highlights the emergence of NCDs as a field of interest and advocacy within global health from 2000 onwards and which they argue, by 2015 had formed an 'extremely dense' cluster of publications closely tied to those of the Global Burden of Disease. Yet, while NCDs may compose a significant realm of publication within the 'fuzzy intellectual domain' of global health (Weisz, Cambrosio and Cointet 2017), such proliferation has not been matched by either funding or political prioritisation (Herrick 2019). This is despite NCDs being

the only health issue other than HIV/AIDS to have accomplished a UN HLM prior to 2020. The marginal status of NCDs also means, by extension, that its imbrication within the coloniality of global health has been under-researched and the category's presence within the decolonisation debate has been minimal. This paper represents a first step towards addressing this by exploring the ecosystems of authorial expertise – their social and spatial contours - revealed by a bibliometric analysis of key NCD documents from 2000-2020. Doing so may reveal the same kinds of North-South asymmetries that characterise the broader global health field, but it also and importantly shows the social networks that are built around expertise, their geographical manifestations and, crucially, what (where and who) is left out. Empirically it also reveals *who* the central authorial experts have been in driving forward the NCD agenda during this crucial time. Thinking about ecosystems of authorial expertise thus introduces a greater degree of spatial complexity, mobility and connection. In so doing, it also forces reflection on some of the methodological challenges in exploring the kinds of core-periphery dynamics that have animated so many calls to decolonise global health, but that in reality often necessitate a deep qualitative understanding of individual training pathways, career trajectories and social networks of experts in the field (see Connell et al. 2018).

Methods

This research exercise was based on three initial questions: (1) Who are the authorial experts in the field? (2) How has authorial expertise changed over time? And (3) what are the geographies of authorial expertise? To explore these questions, the research team compiled a database of the key NCD reports, policy papers, strategies or journal series that fed into the UN HLM process published from 2000 onwards. These were overwhelmingly from the WHO, but also included publications from the World Bank, the papers comprising four *Lancet* NCD series and the report of the *Lancet Taskforce on NCDs and Economics*. The *Lancet* series were

included due to the journal's status as a 'major sounding board' and advocacy tool within the global health domain (Weisz et al. 2017). The WHO and World Bank publications were identified through an initial search of electronic archives (search term "chronic disease" AND/OR "noncommunicable disease"). Importantly, while there is a raft of regional and country-level publications on NCDs, the aim of the exercise was to ascertain the geographies of authorial expertise for NCDs as a problem of *global* health. Consequently, the search returns were manually filtered to only include those publications that were "global" in scale. A final list of 43 documents was compiled (see appendix 1).

For each of these documents (and each of the papers within the *Lancet* series), a database was created with the publication type, each of the authors, their employer or *primary* listed affiliation (at the time of authoring the document), its geographic location (city and country) and employer type (i.e. university, NGO, international organisation etc). Each of these entries was weighted equally (Chaccour 2018) and assigned a unique identifier, running to 177 in total and arranged chronologically. The list of authors and their affiliation(s) was usually provided at the beginning of the report, in the acknowledgement section or in the archive return. For some WHO reports in which over 30 or more authors were listed, only those credited as main, principal or primary authors were included in the database. In rare cases where no author was credited, the report was described as anonymous. Where possible, all cell entries were verified by checking the professional pages of the individual authors and institutions. This database is available open access (reference hidden). We also cross-checked the exact location of different departments or offices within an institution. To examine who the experts in the field are, we analysed counts of individual authors. To analyse and visualise the geographies of expertise and their change, from the database we created maps of the counts of authors of *Lancet* series papers by country (reference hidden). The results of this analysis are also available open access and are explored below.

Discussion

Uneven ecosystems of expertise

The ecosystem concept was first coined in print by English botanist Arthur Tansley in a 1935 paper (Willis 1997) who argued that ecologists should be concerned with ‘the whole system... not just the organism-complex, but also the whole complex of physical factors forming what we call the environment of the biome’ (1935, 299). While little used for the next two decades, Tansley’s term quickly gained traction thereafter for its capacity to view ecosystems as dynamic, interactive, scalar and, later, for its express use to denote bounded geographies, however “fabricated” in reality (Fitzsimmons 1996, Blew 1996). Ecosystems are defined by their ‘emergent properties’, adapting and changing over time and have proved to be useful conceptual frameworks within the social sciences (Moran 1990). The term has also entered wider vocabulary and is often used within the global health lexicon as a shorthand denoting its interconnected and dynamic component parts (Gostin, Moon and Meier 2020, Büyüm et al. 2020), although the spatial dynamics of this have been less explicitly interrogated. Part of the decolonisation critique rests on the uneven and bounded geographies of this “ecosystem” (Global Health 50/50 2020), in which power and resources are overwhelmingly concentrated in what might be called ‘centres of calculation’ (Latour 1987) most often found in HICs. This then leaves legitimate expertise found in LMICs positioned outside an ecosystem that too often tends towards – to borrow another phrase from ecology - ‘dynamic equilibrium’ or, in other words, the maintenance of the *status quo* (Moosavi 2020). This is not to suggest that are no southern ‘centres of calculation’. Indeed, research mapping university global health partnerships, for example, shows an array of (anglophone) Sub-Saharan African global health hotspots, such as Kampala, Nairobi and Cape Town. Mbaye et al (2019) term these ‘star researcher countries’ but caution that these ‘mostly include only a handful of star researchers’,

as recognised by official parameters of excellence decreed in the global North. This points to an under-appreciation of the power relationships and relationality (i.e. reliance on Overseas Development Assistance funds from HICs) that define such clusters of expertise (Crane et al. 2017).

Our research suggests that the ecosystem of authorial expertise on NCDs is heavily clustered, for obvious methodological reasons, around the primary centre of calculation that is the WHO. The important question is therefore among whom and where else is authorial expertise on NCDs to be found? Put another way, who does the WHO collaborate with? Within the WHO, the key authorial experts driving forward the early agenda from the 2000 *Global Strategy on the Prevention and Control of NCDs* include Ala Alwan (then Director of the Department of Noncommunicable Disease Management), David Maclean (then Director of the WHO Collaborating Centre in Community Health and Epidemiology at Dalhousie University), Ruth Bonita (then Director of NCD Surveillance) and Pekka Puska (Director of the North Karelia Project and for NCD Prevention and Health Promotion at WHO). By the time of the 2002 *World Health Report: Reducing Risks, Promoting Healthy Life*, a different cadre of experts emerged including Christopher Murray and Alan Lopez (then both at WHO), founders of the Global Burden of Disease, whose research showed that of the top ten global risks to health, five were determinants of NCDs (see Weisz et al 2017 for an interesting analysis of the links between the Global Burden of Disease and NCD research). However, it was only with the 2004 *Global Strategy on Diet, Nutrition and the Prevention of Chronic Disease* that a broader consortium of experts emerged including Derek Yach (then Executive Director for NCDs and Mental Health, WHO) and Chizuru Nishida (Nutrition Unit, WHO), Mabel Deurenberg-Yap (Health Promotion Board of Singapore), Shiriki Kumanyika (Perelman School of Medicine, University of Pennsylvania), Ricardo Uauy (London School of Hygiene and Tropical Medicine and the University of Chile) and Jacob Seidell (Department of Nutrition and Health, Free

University Amsterdam). They were joined by Prakesh Shetty and R. Weisel (Food and Agriculture Organisation).

When the documents were analysed to show the top authors by frequency (reference hidden), Robert Beaglehole (who moved to the WHO from the University of Auckland in 2003 to join his wife, Ruth Bonita) holds the top spot, followed by Ala Alwan, Leanne Riley (WHO), Colin Mathers (WHO), Daniel Chisholm (WHO), K Srinath Reddy (Public Health Foundation of India), Melanie Cowan (WHO), Colin Tukuitonga (WHO), Louis W Neissen and Matrin McKee (both LSHTM), Rachel Nugent (RTI International, based in Seattle), Richard Horton (Editor-in-Chief, the *Lancet*), Sania Nishtar (Director, Heartfile, Pakistan), Shah Ebrahim (LSHTM), Shanti Mendis (WHO). Among the remaining top authors, the institutions include WHO, World Bank, University of Oxford, OECD, Union for International Cancer Control (based in Switzerland), University of NSW, and the Young Professionals Chronic Disease Network (based in the US). An important thing to note is that of the top 20 authorial experts, only Shania Nishtar and K Shrinath Reddy, are primarily affiliated to an institution based in the global South. None are affiliated to any African institution.

A temporal analysis of the *Lancet* Series helps demonstrate the expanding remit of the NCD domain. In 2005 (see figure 1), the series comprised five papers and an editorial (by Richard Horton). The first paper on ‘preventing chronic diseases: how many lives can we save?’ (Strong et al. 2005) brought together experts on the disease burden (WHO and the University of Sydney), a second on the ‘stepwise’ approach to NCDs was entirely authored by WHO, a third paper critiquing the absence of NCDs in the Millennium Development Goals was authored by the World Heart Federation (based in Geneva), a fourth paper ‘Responding to the threat of chronic disease in India’ (Reddy et al. 2005) was authored by K Srinath Reddy and authorial experts from the Indian Council of Medical Research, the Ministry and health and Family Welfare of India and WHO. A final paper on ‘Preventing chronic diseases in China’ (Wang et

al. 2005) brought together authorial experts from WHO, China Centre for Disease Control and Prevention and the Ministry of Health. In 2007, the series comprised an editorial by Richard Horton and a further five papers (see figure 2). This time, none of the papers had a particular country focus. Across all twenty authors featured in the series, only K Srinath Reddy and Rafael Lozano (University of Mexico) were affiliated with an LMIC-based institution in their paper on preventing of cardiovascular disease in LMICs (Lim et al. 2007). Another paper on the burden and cost of NCDs in LMICs was authored only by WHO staff (Abegunde et al. 2007). The final call to action paper was jointly authored by Robert Beaglehole (University of Auckland), Shah Ebrahim (LSHTM), K Srinath Reddy (Public Health Foundation of India), Janet Voûte (World Heart Federation, based in Geneva) and Stephen Leeder (University of Sydney).

In 2010, the series had expanded to an editorial (Richard Horton and Robert Beaglehole) and a further seven papers (see figure 3). Of all these, only six authors were affiliated with organisations in LMICs (Heartfile, Ministry of Health - Mexico, University of Sao Paulo, Universidade Estadual Paulista Julio de Mesquita Filho, Aga Khan University and the Public Health Foundation of India) with one further author holding a joint affiliation between the London School of Economics and the University of Ghana. It also featured a paper on the health systems strengthening in LMICs (Samb et al. 2010) in which it is notable that only one author – Sania Nishtar – was based in a LMIC organisation. Finally, this series featured an interesting position paper (Mbanya et al. 2011) authored across four disease federations (International Diabetes Federation - Brussels, International Union Against TB and Lung Disease - Paris, Union for International Cancer Control – Geneva and the World Heart Federation - Geneva). It is also of note that by late 2010 these four organisations would have forged an official collaboration in the form of the NCD Alliance which has gone on to play a core role in driving the NCD agenda forwards.

The 2013 series again had an editorial (Richard Horton) and a further eight papers (see figure 4). By this time, the range of authors and institutions had grown demonstrably. While the first agenda-setting paper was authored by Robert Beaglehole, Ruth Bonita (by now both at the University of Auckland) and Richard Horton, this time authorial expertise emanated from a far wider range of countries: Rwanda, China, Brazil, Iran, Japan, Colombia, Kenya, Malawi, Cambodia, Thailand, Mexico, South Korea, Pakistan and Uganda. Thus, even if the majority of papers were authored from institutions in the USA, UK, Australia, New Zealand and Switzerland and other HICs; the range of countries, types of institutions and proportion of authorial experts from LMICs grew significantly throughout the Lancet Series. This expansion is no doubt due to the broadening of the issues encompassed within the ‘NCD space’ which by 2013 included questions of global accountability (Beaglehole, Bonita and Horton 2013), sustainable development (Alleyne et al. 2013, Clark 2013), national policy responses (Bonita et al. 2013, Di Cesare et al. 2013), the corporate determinants of health (Moodie et al. 2013), access to essential medicines (Hogerzeil et al. 2013) and health system responsiveness (Atun et al. 2013).

The 2018 report of the Lancet Taskforce on NCDs and Economics (Nugent et al. 2018), itself a series of eight papers (see figure 5), included authorial expertise from Barbados, Nepal, Thailand, India, Lebanon, China, South Africa and Bangladesh. Yet, among a group of almost 50 authors, only 11 had LMICs affiliation. Like the other series, it was notable that a paper on tackling socio-economic inequalities and NCDs in LMICs (Niessen et al. 2018) included only two authors from LMICs (Bangladesh), both of whom held joint appointments with HIC institutions (in Sweden and the USA). Of the remaining authors, five were from US institutions and two from the UK. The opening paper in the series (Nugent et al. 2018) had eight authors from the USA, UK, New Zealand and Australia. While the Taskforce report may have seen a

broadening of the geographies of authorial expertise, the HIC dominance of the introductory paper suggests that the ecosystem has a long way to evolve.

The NCD ‘exception’?

NCDs occupy a curious space in global health (Allen 2016). They are the majority burden of disease, but arguably subsist at the far margins of the architecture and endeavour of global health. Political awareness and national-level action on NCDs have doubtlessly increased dramatically over the past 20 years, but global health has largely continued to self-define itself through the parameters of communicable disease. The NCD agenda has also long been hampered by the lack of any coherent advocacy movement, despite the concerted efforts of the NCD Alliance to establish a fast-growing network of national and regional-scale alliances (Herrick 2020). This analysis has shown that the ecosystems of authorial expertise deviate quite distinctively from the global health geographies found in infectious disease research and publication (Dimitris et al. 2021). Indeed, our research shows that of the 452 separate author entries in our database, only 12 were affiliated to institutions located in Africa and five of these were WHO country or regional offices on the continent (Egypt, Malawi and the Democratic Republic of the Congo). Therefore, an analysis of NCD authorial expertise reveals quite different ‘hotspots’ or ‘star researcher countries’ than is the case when the totality of global health with its clear concentration in sub-Saharan Africa is explored. Obviously starting from the key documents of the WHO, World Bank and *Lancet* is a different exercise than tracing authorship on academic publications on NCDs and by necessity will reveal quite different ecosystem dynamics.

One exceptionally important omission when only looking globally is that the hugely important work of the Caribbean countries through CARICOM and PAHO and the work of George

Alleyne and Trevor Hassell of the Healthy Caribbean Coalition (among many others) in getting NCDs onto the global agenda goes under-represented (particularly in the *Lancet* series). The *Port of Spain Declaration for NCDs* (2007) and the *Strategic Plan of Action for the Prevention and Control of Non-Communicable Diseases for Countries of the Caribbean Community 2011-2015* reveal an immensely important ecosystem of authorial expertise that fed directly into the UN Declaration on NCDs. It is also important to note that George Alleyne and colleagues authored a notable number of position papers setting out the “politics” of the UN HLM (Beaglehole et al. 2011a, Beaglehole et al. 2011b, Alleyne, Basu and Stuckler 2011, Alleyne, Stuckler and Alwan 2010). This omission aside, the exercise undertaken here remains an important one for what it shows about the kinds of expertise that provoke influence and leverage within the international political sphere. These documents do not just report research, they serve a clear political purpose and are part of a tranche of evidence that was used in the UN HLM process. In this case authorial expertise denotes patterns of individual and geographic inclusion and exclusion from these processes. They also reveal the close connections of what some term “thought leaders”, collated from a range of universities, international organisations, research institutes and, increasingly through time, disease federations. This exercise thus not only charts the changing loci of presumed and actual political influence, but also reveals – in stark contrast to earlier advocacy endeavours for HIV/AIDS - the ongoing lack of significant civil society representation within these ranks.

The Challenge of Representation

When exploring the ecosystems of expertise in the field of NCDs, several methodological issues emerge that speak clearly to the literature on global health authorship. First, one important question that is rarely asked is where people’s expertise *emanates from*. Most studies of authorship use current author affiliation (Dimitris et al. 2021) in order to explore whether

these are in HICs or LMICs. We have not yet seen a study that instead looks at where authors were born or the country/ countries from which they received their degrees (Moosavi 2020). It is thus significant that if we were to instead have used nationality at birth for the top 20 authorial experts in our database, six people would be from LMICs. The methodological and ethical reasons for this are clear, but the challenges in doing this also forces a broader discussion of academic mobility, training opportunities and careers that may reveal the continued dominance of a small coterie of core institutions, but also offer the scope for more expansive examples of transnational mobility (Abimbola 2019). Drawing on our chronological database, it is notable that most of the reoccurring experts retained the same affiliations throughout the two decades in question, most commonly where twin university and organisational affiliations were maintained throughout. Finally, it is also important to note that affiliations are often used creatively and strategically. As Chaccour (2018) thus notes, ‘many researchers from high-income countries with a track record in global health use multiple affiliations, and prefer their LMIC affiliation when applicable for fee waivers, as is the case for *The Lancet Global Health*’. While there is mobility in affiliative use, this benefits far fewer researchers from LMIC countries, a point repeatedly emphasised by those arguing for the decolonisation of global health (Bhakuni and Abimbola 2021).

Conclusion

This paper has examined the question of authorial expertise through a particular set of “global” documents. These documents are used as advocacy tools, to document the state of a particular domain of public health and as instruments of accountability. Their findings and stance often hope to reposition certain health issues (in this case NCDs) within a particular “problem space” thereby making it more amenable to intervention and political action (McGoey, Reiss and Wahlberg 2011). Yet, these documents also demonstrate the same kinds of ‘imbalances in

authorship’ highlighted by Abimbola (2019, 4). And, following him, the ecosystems of authorial expertise that we have traced are also ‘a tangible proxy for concerns about power asymmetries in the production (and benefits) of knowledge in global health’ (*Ibid*). These concerns are particularly apposite in the case of documents specifically arguing the case for greater attention to NCDs in LMICs with either no or very few LMIC-based authorial experts. Crucially, while these omissions have become slightly less stark and less common over time, they are still marked, particularly with regards to representation from Africa.

While tracing authorship of academic publications would no doubt have revealed different geographical formations, when NCDs as a *global* problem are used as the analytical starting point it is clear that authorial expertise operates in fairly tight networks. As Daftary and Viens remind us, ‘the global health research community does not exist in a vacuum. This community is structured and regulated by an architecture and agenda that shapes both how we conceptualize particular global health problems as well as guides our approach to these problems’ (2020, 61). This is important: the ways in which the global community has come to view NCDs as a “problem” (and therefore, arguably, the rationale behind action or inaction) can be traced to this cache of documents. The ecosystems of authorial expertise are the most visible manifestation of far wider, emergent circuits of knowledge and advocacy on NCDs across global North and South. This is therefore not simply a problem of representation or representativeness in the “NCD space”, it is the task of ‘undoing what those imbalances represent - a continuity of the colonial project in global health’ (Abimbola 2019, 4). This extends far further than who gets to speak ‘for’ or ‘about’ certain issues in global health, but also how those issues are imagined as global health problems in the first place. Put simply, how NCDs are imagined geographically – as a problem of/ for the global South – cannot be dissociated from the authorial expertise that constructs their problematisation.

The first task here is to reveal the issue. The second, to borrow a popular concept from the decolonisation debate, is to ask what a more ‘pluriversal’ ecosystem of NCD authorial expertise might look like (Affun-Adegbulu and Adegbulu 2020) or how the expertise that does exist might be rendered more visible. The example of the pivotal role played by CARICOM and its key authorial experts and advocates, for example, needs to be better understood within the contemporary history of NCDs. Doing so demonstrates the extent to which this “global” enterprise really started life as an initiative *from the South*. The work of the *Lancet* NCDI Poverty Commission to ‘reimagine’ NCDs as a problem of the poorest billion means that its collaborator network now represents a powerful alternative ecosystem of authorial expertise given that the overwhelming majority of members are located in Sub-Saharan Africa, as well as Haiti, Afghanistan, India, Cambodia and Nepal (Bukhman et al. 2020). Given the failure of the NCD agenda to gain the traction that might be expected (and is certainly needed) given the burden of disease it represents, opening up authorial expertise to a wider plurality of voices can only help in the quest to leverage strategic opportunities for greater prioritisation of the disease category.

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