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A pragmatic approach to equitable global health partnerships in academic health sciences

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ABSTRACT

Global partnerships offer opportunities for academic departments in the health sciences to achieve mutual benefits. However, they are often challenged by inequities in power, privilege and finances between partners that have plagued the discipline of global health since its founding. In this article, a group of global health practitioners in academic medicine offer a pragmatic framework and practical examples for designing more ethical, equitable and effective collaborative global relationships between academic health science departments, building on the principles laid out by the coalition Advocacy for Global Health Partnerships in the Brocher declaration.

SUMMARY BOX

⇒ Inequities in power, privilege and finances influence academic health science (AHS) departments hoping to develop equitable, ethical and effective global partnerships.
⇒ To develop better partnerships, AHS departments should apply key principles outlined by the coalition Advocacy for Global Health Partnerships in the Brocher declaration.
⇒ This manuscript offers a pragmatic model for applying these principles to partnerships between AHS departments in a variety of settings.

BACKGROUND

Global health is a discipline with troublesome roots. Emerging from the 'tropical' or 'colonial' medicine movements of the late 1800s, the field was founded in a desire to both ensure the success of colonial aspirations and provide a humanising face to those efforts.[1 2] In the first quarter of the 20th century, tropical medicine merged into 'international health', but remained haunted by the same sentiments of paternalism and racism that motivated the field's founders.[3] More than a century later, neocolonial and deficit-based thinking continues to plague modern academic global health partnerships.[4]

Patterns of inequity persist in which partners from wealthier, more high-resourced settings have a dominant role at every level of partnership design and implementation. Parties outside the regions where research and project implementation occur frequently direct the development of research questions and project proposals.[5] Discrepancies in which researchers are awarded project funding and manuscript authorship reveal similar trends.[6–9]

Similar patterns impact academic partnerships characterised by learner exchanges.[10 11] Academicians are often eager to set up short-term international learning experiences for trainees, motivated by a desire to improve their learners' understanding of global health systems and care of the underserved, to improve recruitment to their training programmes, and even for purposes of promotion and to have an opportunity to travel.[12 13] However, the movement of trainees and faculty is commonly unidirectional, as only those with sufficient resources are able to pay for travel and benefit from the experience. Simultaneously, some participants may not have adequate language or cultural training to appropriately engage in these experiences. Although participants often report positive feelings reflecting on their travel, the impact on patient outcomes, host colleagues and health systems is undervalued and understudied.[14]

Addressing inequities is critical, as equitably designed partnerships in global health benefit all academic collaborators and their communities. Partnerships focused on exchange of learners and faculty, for example, may garner for all participants new knowledge about comparative health systems and healing

practices, clinical references, and methods of teaching and training. Overall, they may facilitate an exchange of learning and resources with mutual and global benefits.[15–17] Hence, it is preferable to intentionally seek to pursue global health activities thoughtfully and equitably, rather than disengage completely from opportunities for global collaboration.

Over the last decade, a growing sentiment has emerged regarding the need to uproot institutionalised vestiges of neocolonial, imperialistic and white supremacist thinking in global health, as well as the systems of economic subjugation and other coercive pathologies of power that reinforce these approaches.[18] Several groups have published ideas regarding both the need for and possible approaches to reforming specific aspects of global health partnerships, from funding and design of research to authorship of joint findings.[19–22] Several position papers offer recommendations around ethical practices, ranging from challenging the implicit biases and assumptions of individual participants to modifying systems for academic promotion and research.[23–28] Some offer direction on how to connect ethical frameworks to implementation in focused areas of practice. For example, guidelines exist for groups providing short-term training experiences to learners in global health and for large-scale twinning partnerships between clinical service delivery centres in different regions.[29–31]

Authors from a wide range of nationalities and backgrounds have contributed to these calls for action, and some authors from lower-income and middle-income countries (LMICs) have specifically suggested that successful reform demands the active engagement of colleagues at all income and resource levels. The literature holds an implicit challenge for researchers from LMIC contexts to ensure local stakeholder contributions at every phase of global health projects, from design to implementation, data collection and evaluation.[32]

The term academic health sciences (AHS) encompasses the clinical care, research and education of health professionals within a variety of health-related disciplines, including medicine and nursing. Despite a long history of global engagement in AHS, no ethical frameworks offer pragmatic approaches for AHS departments to engage in more responsible partnerships that seek in their design to address systemic biases, inequities and oppression that linger in the global health field. In addition, previous guidelines have often taken a unidirectional focus, offering guidance for academic health centres in high-income countries as they look to partner with colleagues in AHS in lower income countries. The authors propose a set of principles to guide AHS departments around the world in developing more responsible, ethical and equitable partnerships true to the philosophies, values and unique traits of AHS, and offer examples of what these principles may look like in practice. This approach may be used in any AHS partnership, regardless of the location of the partners involved.

It is important to note that direct interactions between AHS partners are impacted by complex layers of influences, from interpersonal to institutional factors, cultural and economic considerations, and larger aspects of global politics and the global economy.[33] Donors and funders, for example, influence global health partnerships through their choice of which projects to support monetarily and what types of grants and funding awards to offer. As other authors have written extensively about needed reforms by donors and funders in global health partnerships, this manuscript will focus instead on how funding and other factors may be approached practically between AHS partners.[34] In addition, interactions are impacted not only by inequities among partners and donors, but also by complex local gradients of power that exist between AHS and community members. Factors such as class, tribe, race locally cannot be generalised across LMICs, and therefore, will not be a focus of this manuscript but must be mentioned as important considerations for partnerships.

Eight AHS faculty came together to jointly engage in this work. The authors represent five countries across Africa, North America and South America, and a range of high-income, middle-income and low-income settings. Each has at least 10 years of experience with international collaborations. All have either currently or previously engaged in the design and/or implementation of multinational global health partnerships in the AHS.

The authors performed a literature review to identify existing publications and guidelines relevant to concerns around the equity and ethics in global health partnerships, and proposals for new systems and structured approaches. Key manuscripts are referenced throughout this paper. Following this, the authors drafted by consensus a summary of key human elements/principles of global partnership through group discussion, informed by both literature review and the experiences of representative academicians and their institutions, with consensus agreement on final approach. This article applies these principles to hypothetical ‘exemplars’, drawn from the experiences of members of the group and literature review, and relating to technical aspects of an AHS department’s functions, to demonstrate how they may be applied in practice.

KEY PRINCIPLES OF AHS GLOBAL HEALTH PARTNERSHIPS

AHS departments’ core activities include caring for people, teaching and creating knowledge.[35] Health sciences are ever evolving, with new knowledge frameworks and new challenges, and there is a need for AHS departments to be system integrators and bridge translational gaps in the local and global spheres.[36] While individual disciplines within health sciences have various technical skills, collaborations and partnerships between AHS across countries, in global health, advances the understanding of health and health services.[37]

Table 1 Pragmatic applications of key principles in academic health sciences global health partnerships

Key principle	Definition	Pragmatic applications
Solidarity	Solidarity entails collaboration with the goal of ensuring mutual benefits characterised by bidirectional investments, gains and learning.	► Ensure bidirectionality of learner and faculty exchanges ► Recognise the value of the diverse investments and contributions of all partners (knowledge, human resources, etc) ► Provide funding to support travel if there is inequity in access to financial resources between partners
Humility, cultural sensitivity and mutual respect	True partnership begins with a shared sense of humanity, demonstrated in practices of humility and respect among members of diverse populations and partnerships.	► Make a commitment to ongoing introspection and evaluation of implicit biases and goals ► Plan for equitable authorship representation among members of the research team, guided by intellectual rather than financial investments of partners[45] ► Solve problems using an open-ended, shared exploration of possible strategies and outcomes, rather than assuming a single method or solution is correct ► Approach partnership understanding that all partners have resources to bring, rather than seeing the relationship as an opportunity address a perceived 'deficit' in another ► Prioritise in all partnership activities the well-being of individual partners and patients, as well as impacted families and communities ► Learn about power gradients existing in each AHS partner that may impact collaboration
Compliance with applicable laws, ethical standards and codes of conduct	Identification and compliance with applicable laws, ethical standards and codes of conduct in all partners' localities is a pragmatic extension of previous principles related to solidarity, respect and humility.	► Observe rules and restrictions on scope of clinical practice and licensure in all international exchanges
Sustainability and capacity-building	Consider how work, once started, will be maintained over the long term. The ideal goals of a global health partnership should be to improve the capacity of all partners, rather than developing short-term solutions.	► Emphasise capacity-building of all partners involved ► Redesign models involving short-term learner or faculty placement to use and develop skills of all partners ► Consider the knowledge and experience that each academic partner can bring towards capacity-building of the other
Shared accountability	Shared accountability involves codevelopment of monitoring, evaluation and learning frameworks at the outset of partnership which define the metrics used to identify success and include defined times and approaches for evaluating the partnership by these metrics.	► Collaboratively develop a monitoring, evaluation and learning (MEL) framework at the start of the partnership ► Ensure MEL frameworks clearly identify the overarching goal of the work and outline the objectives, outcomes, activities and indicators used to assess if the goal is met ► Detail how partnership funds will be used in the partnership plan to ensure equity in distribution of funding and allow for monitoring of resource utilisation during implementation ► Ensure that partners are aligned on how data used to assess indicators will be collected with what frequency ► Determine at the start of the partnership with what frequency the success of the partnership will be evaluated, and how the results will be shared and reviewed to inform future activities

AHS, academic health science.

The authors propose a model of five key principles, grounded in those outlined in the Brocher declaration developed by the coalition Advocacy for Global Health Partnerships,[29] and provide examples of how these may be applied in global AHS partnerships (see table 1).

Solidarity

Rationale

Solidarity within global health partnerships compels collaboration with the goal of designing a mutually beneficial model of engagement characterised by bidirectional investments, gains and learning.

Key to this principle is a focus on collaborative design from the outset, in which all partners are equally empowered to define the needs and activities of the partnership.

Challenges to implementation

There are multifold challenges to implementing a partnership built on the principles of solidarity. Inequity in available funding for research and/or travel often prompts academic departments to develop partnerships from a unidirectional perspective, resulting in disparities in which partners are able to engage directly in research and travel, and leading to benefits accruing disproportionately to academicians from more highly resourced settings. Bidirectionality, as an extension of solidarity, emphasises that all partners should be able to engage in mutual benefits and learning. Historically, a misunderstanding of what is truly gained or given by each partner has challenged many partnerships in developing true bidirectionality. For example, bidirectionality is not truly

embodied by a model in which a host institution in a comparatively lower-income setting 'opens its doors' or provides resources such as interpreters to their higher-income colleagues.

The principle of solidarity recognises the investments each partner contributes that may go beyond funding. An institution with comparatively lesser funding may provide tremendous human resources, equipment and other non-financial contributions that are not always equally recognised and valued as investments in the partnership.

Pragmatic considerations

Frameworks for global health partnership often cite bidirectionality as a key principle. The premise of bidirectionality is for both partners to commit to a relationship that is grounded in continuous cooperative learning and investment. An example of a true bidirectional relationship is that trainees and faculty from each institution participating in a learning exchange have an equitable opportunity to visit their partner for an educational experience. To address disparities that may exist in access to personal or institutional funds to facilitate travel, individuals from a higher-income setting might be encouraged to pay for their own travel, while individuals from the lower-income setting might receive funds to support their participation.

Bidirectionality also implies the development of an academic milieu in which each partner is recognised as both a learner and a teacher. For example, if the partners engage in collaborative didactic sessions, they take turns in serving as the teacher and learner. Unfortunately, in many situations, the default tends to be that the partner in the more financially resourced institution becomes the teacher, perpetuating a colonialist and oppressive educational environment.

Humility, cultural sensitivity and respect

Rationale

The principles of humility, cultural sensitivity and respect encompass the communitarianism and equity ethic that should be the driving force in global health. These principles should form the core of AHS' identity, and are key to successful global health partnerships.

Challenges to implementation

Commonly accepted practices for grant and research funding may fundamentally contradict principles of humility and respect. A shared commitment from the start of a project to discontinuing any programme that no longer benefits or even actively harms one partner may come into conflict with donor expectations and timelines related to completion of research or project activities. Similarly, pressure to claim the role of first, second, or senior author on research publications for the purposes of academic promotion may encourage inequity in claimed intellectual ownership of shared learnings, fuelled by an implicit expectation that the institution making a financial investment in publication fees or other research costs should receive priority in authorship.

Pragmatic considerations

Identifying and disengaging from ingrained and inequitable practices, approaches and behaviours requires ongoing introspection and effort, and is unlikely to ever result in a perfect outcome. Nevertheless, it is essential for all partners to commit to this process continually, especially as it relates to assessing and challenging their own motivations. Cultivating a practice of challenging internalised or even verbalised assumptions regarding what is a 'right way' to practice clinically or a 'right solution' to navigating research challenges helps to facilitate constant growth in cultural sensitivity and humility.

To achieve this, partners should approach conversations using open-ended questions to explore mutually ideal solutions, such as 'how would this look if…' rather than 'is this solution acceptable?' Using this approach in the spirit of appreciative inquiry would allow for partnerships to build based on respectful conversations.[38]

Developing foundational principles and approaches to monitoring and evaluation from the outset of a project facilitates multidirectional feedback and ensures early identification of any problematic practices or outcomes.

Critically reviewing prior patterns of engagement is also critical to academic departments' success in embracing a decolonised approach to global health. For example, this might involve reconsidering learner exchange models focused on short-term clinical training in settings where learners lack the language skills, cultural training and licensing to provide appropriate clinical care.

Finally, it is essential to approach partnership from an 'assets' rather than a deficit approach, identifying what all partners have to offer towards the partnership rather than using a more frequented deficits approach, in which partners from a perceived higher resourced setting see themselves as filling the needs of another partner.

Compliance with applicable laws, ethical standards and codes of conduct

Rationale

Compliance with applicable laws, ethical standards and codes of conduct in all partners' localities is in essence an extension of previous principles related to solidarity, respect and humility.

Challenges to implementation

Many global health partnerships face a tension between tight timelines to meet travel requirements for visiting personnel or complete research activities, and the extended time perceived necessary to abide by legal and professional requirements for practising clinically or conducting research work across regional borders. Sacrificing a commitment to legal compliance is often seen as an acceptable choice when striving for expediency in partnership activities. Out of a desire to meet partnership objectives, goals and timelines, or even motivated by

a sense of good will, partners may obtain tourist rather than appropriate business visas, or circumvent the acquisition of work permits and governmental approvals while engaging in academic activities. Short-term clinical engagements or faculty exchanges may fail to go through the process of applying for medical licensure in the locality to which they plan to travel.

Pragmatic considerations

Approaches such as those noted above pose serious legal risks to partners in the localities whose requirements are being subverted and also challenge a basic notion of mutual respect—if practising clinical medicine without an appropriate license would not be acceptable in one country, it should never be presumptively accepted as a solution in another and is illegal.[39] Partners should commit both relationally and technically at the outset of the partnership to compliance with laws and ethical standards, allocating time to considering the influence on and impacts of these principles to project activities, and exploring and outlining the ethicolegal aspects of the specific work activities and how they will be met.

Rationale

An extension of solidarity and mutual respect is the consideration of how work, once started, will be maintained. The ideal goals of a global health partnership should be to improve the capacity of all partners, rather than developing short-term solutions.

Challenges to implementation

Grant-funding for both non-profit programming as well as academic research is almost always time-limited, which is a notion that comes into direct conflict with principles of sustainability.

The very definition of capacity may be seen in a conflicting light depending on which partner might be asked to define it, and has been the hallmark of the 'deficit'-based approach in global health.[40] An exchange in which a faculty member travels from one country to another to provide instruction, for example, might be seen as capacity-building of the students they will train, but the investment in funding and onboarding of that visiting educator might also deflect resources from experts and knowledge that already exist locally. This may result in diverting investments away from local faculty, who might desire the ability to focus their efforts on teaching and training of their learners but lack the same resources to do so.

Pragmatic considerations

Committing to principles of sustainability and capacity-building compels us to re-evaluate existing models for global engagement. For instance, abiding by principles of sustainability and capacity-building may require pivoting partnership models centred around short-term, unidirectional clinical rotations by learners to focus instead on shared identification of training needs for existing healthcare personnel in both regions and consideration of how mutual sharing of knowledge and learning may be achieved. Principles of bidirectionality and mutual respect obligate partners to recognise that there are opportunities for capacity-building in all AHS centres, and each partner may be able to both give and receive experience and knowledge towards this end.

Shared accountability

Rationale

An approach that ensures all the above principles are met in practice is a commitment to the principle of shared accountability, in which monitoring, evaluation and learning frameworks encapsulating these principles are designed at the outset of partnership. These frameworks should define the metrics used to identify success and include defined times and approaches for evaluating the partnership by these metrics.

Challenges to implementation

The objectives, outcomes and activities of partnership and prioritisation of these elements may be a source of conflict between parties and may be heavily influenced by the organisations, which provide the resources for the partnership activities, such as academic institutions, government funders and/or private donors.

Pragmatic considerations

Using a monitoring, evaluation and learning framework for every global partnership from the outset may help to identify differences in values and priorities and ensure that partners are aligned in the objectives and goals of the work from the start. Embodying the principles of humility and cultural sensitivity in action, partners should identify what their own motivations and the motivations of relevant institutional bodies and/or funders may be. Collaboratively working to synchronise these motivations through the sequential development of a shared partnership goal, objectives, outcomes, activities and indicators may help to identify and navigate any potential areas for conflict. Mutually identifying the frequency and practical approach to evaluating how the partnership activities align with this framework in advance further ensures that expectations are consistent between partners.

CONCLUSION

Global health partnerships may offer tremendous benefits to AHS departments, facilitating an exchange of knowledge and resources that can improve the capacity of all partners, from the departments themselves to the wider health systems and communities with whom they partner.

However, to achieve these benefits, it is critical to acknowledge the complex history of inequities both locally and globally that have existed since before the modern field of global health first began to emerge, and actively work to deconstruct these inequities.

AHS partnerships in global health have historically been for scientific, humanitarian or strategic reasons.[41–43]

There are many aspects of global health partnerships that are influenced by problematic systems of oppression and systemic inequities that exist within the world at large and academic departments have followed the structures of systematic inequities in their function.[44] Historical political oppression or resource restriction may result in differential abilities of academic partners to fly to a joint meeting or send a learner abroad for an opportunity to understand how another health system works. These inequities may impact partnerships between members of the Global South as well as between the Global North and South. They may exist in any partnership in which academic institutions have access to differing levels of political power or financial or other resources.

This framework offers a pragmatic approach to achieving these principles in action. It calls for an equity-based approach to partnerships. The goal of the movement to decolonise global health systems is not to do away with global health activities entirely, but to prompt individuals and institutions to work as ethical actors for a higher level of mutual respect, solidarity and justice within partnerships.

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