ENACTING AN ETHIC OF CARE AND RESPONSIBILITY IN GLOBAL HEALTH PARTNERSHIPS

A CONSENSUS STUDY OF
THE UGANDA NATIONAL ACADEMY OF SCIENCES

Sciences for Prosperity

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1 Please refer to Appendix 1 for biographies of the experts listed in this section.

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FOREWORD

Dear Stakeholders,

From the heart of Africa, a continent that has long borne the brunt of health disparities, emerges a clarion call for change in the way we conduct ourselves within global health partnerships. This call, co-created with experts from Asia, South America, Europe, and North America, is rooted in an unwavering belief in the power of partnership, the strength of community, and the resilience of the human spirit. It is a call that recognizes the interconnectedness of our global health, acknowledging that the health of one nation is inextricably linked to the health of all. The time has long passed when we speak from a position of weakness and victimhood. To that end, this consensus study report gives us a refreshing perspective on our collective power to reject any global health partnership that promotes power imbalances and dehumanization.

As a physician and public health leader who has witnessed firsthand the devastating impact of health inequities, I have come to understand that true progress can only be achieved through partnerships built on a foundation of trustworthiness, humility, care for one another, and shared responsibility for the investments in and results of our partnerships. The voices of those who do not have money, often marginalized in global health discourse, offer invaluable insights into the complexities of health challenges and the innovative solutions that emerge from communities on the front lines. Centering these voices and experiences sets us on a journey to discover equity in practice.

This consensus study report, a culmination of collective wisdom and lived experiences, provides a roadmap for navigating the complexities of global health partnerships. It challenges us to move beyond the traditional donor–recipient paradigm and embrace a model of co-creation and shared ownership. It calls for a reimagining of capacity strengthening and recognizing the inherent strengths and knowledge that exist within communities. It challenges those of us from the Global Majority (or Global South) to realize our critical

role in leading the charge in addressing the inequities that we see all around but often discuss only in private. The time has come for us to stand together, along with our genuine allies, to chart a more positive and relational approach to global health partnerships. In so doing, we do not forget the gains from some of the partnerships we have engaged in over the decades. They give us hope and inspiration to overcome complacency and defeatism.

This report based on evidence about humanizing global health partnerships complements all the work done in previous quantitative, data-driven reports. Although useful, those previous reports sometimes neglect to address the relational, human component, on which all our work rests. The present report is a reminder that equity starts with the way we treat each other as individuals, institutions, and nations. Every stakeholder, at every level, has a contribution to make to achieving equitable global health partnerships.

I thank the Committee on Equity in Global Health Partnerships, convened by the Uganda National Academy of Sciences for this timely, succinct, and accessible report. It has a lot of wisdom and practical advice for all of us.

Our best days are yet ahead!

FOR GOD AND MY COUNTRY.
Hon. Dr. Jane Ruth Aceng Ocero
Minister of Heath
Republic of Uganda

KEY DEFINITIONS

Effectiveness: The extent to which a partnership achieves its stated goals and objectives, often measured by improvements in health outcomes, capacity building, or other agreed-upon indicators.

Efficiency: The ability to achieve the desired outcomes with the optimal use of resources, minimizing waste and maximizing productivity.

Equity: The fair and just distribution of benefits, risks, and resources among all partners, with special attention to addressing historical and structural inequalities.

Global Health: An area of study, research, and practice that prioritizes improving health and achieving health equity for all people worldwide.[1]

Global Health Equity: Global partnerships and processes that result in fair health outcomes for people and the planet.[2]

Global Health Partnership: A collaborative arrangement between two or more organizations or entities, often from different countries, to address global health challenges and promote health equity.

Partnership: A formal or informal agreement between two or more parties to work together to achieve a common goal.

Success: The achievement of both intended outcomes and equitable processes, including sustained positive impact on health and well-being, capacity strengthening, and mutual benefit for all partners. It also includes building positive relationships and relational practices.

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1 Taken from the more detailed definition by Koplan et al. (2009): "Global health is the field dedicated to improving health and achieving health equity for everyone globally. It focuses on transnational health issues and solutions, involves collaboration across disciplines, and combines prevention with individual care" (p. 1995).

2 From the definition proposed by August et al. (2022): "Mutually beneficial and power-balanced partnerships and processes leading to equitable human and environmental health products on a global scale" (p. 3).

CONSENSUS STUDY PROCESS

Consensus study reports, the signature advisory products of the Uganda National Academy of Sciences, provide evidence-informed policy advice to the Government of Uganda. These reports also act as a bridge between scientific research, policy development, and implementation. While focused on government science advice, the Academy recognizes the diverse sources of information available to policymakers, communities, and other stakeholders. Therefore, consensus study reports also aim to inform various groups, including civil society organizations, businesses, academia, and the communities they serve. Ultimately, these studies strive to make science a cornerstone of development at the national, continental, and global levels.

Before undertaking a consensus study, the Academy conducts listening tours to gain a comprehensive understanding of common challenges within the stakeholder groups it serves. It then aggregates and reviews the input received, identifying pervasive themes. For this consensus study, consultations with global stakeholder groups highlighted that equity remained elusive in global health partnerships. A colloquium organized by the Academy and Advocacy for Global Health Partnerships, held alongside the World Health Assembly on May 22, 2023, underscored the need for more evidence-informed dialogues on the relational challenges within global health partnerships. The colloquium, generously hosted by Gavi, the Vaccine Alliance, made it clear that an undertaking beyond a workshop could lay the groundwork for more sustained discussions and improvements in practices at both individual and institutional levels.

Consequently, the Academy convened a multidisciplinary expert committee to undertake a consensus study on how to infuse global health partnerships with practices that reinforce equity. Committee members served pro bono and in their individual capacities as subject matter experts, completing bias and conflict of interest checks.

Through a combination of virtual and in-person meetings, the expert committee guided the study secretariat on key questions and sources of evidence that would shape the report. Based on their deliberations, the secretariat conducted more comprehensive searches for relevant literature, including academic databases for peer-reviewed literature, practitioner reports, and grey literature. This resulted in a literature synthesis based on over 375 potentially relevant sources,[3] which formed the evidence base for the expert committee's conclusions and recommendations.

With the literature synthesis complete, the committee drafted an initial report, which they then reviewed rigorously. In this process, the committee identified gaps in the literature and refined their focus on overarching conclusions and recommendations. The committee followed this iterative process for subsequent drafts of the report.

Once the committee had prepared a near-final draft, the Academy appointed an external peer review panel to provide critical feedback. The secretariat received and compiled review comments, anonymizing the identities of the peer reviewers. The external reviewers' expertise was aligned with that of the expert committee to the greatest extent possible. After the external review, the Academy appointed another, smaller committee to guide the secretariat in responding to the reviewers' comments. This step ensured that all comments received a response and that no reviewer's comments dominated the revised report. With these steps complete, the secretariat updated the report and circulated it to the expert committee members before their final meeting. Subject to any amendments at this meeting, the committee members signed off on the final report, allowing for copyediting, layout, launch, and dissemination. The word *consensus* means that members of the expert committee agreed on the overarching messages, conclusions, and recommendations, but does not imply agreement on every section, paragraph, sentence, or word in the report.

3 The committee used English reference materials, some translated from other languages. This limitation notwithstanding, we hope audiences across the world will appreciate the relevance of this report.

EXECUTIVE SUMMARY

This report serves as an unequivocal call to action, emphasizing the need for a paradigm shift in the approach to global health partnerships. The report underscores that the persistence of systemic inequities, deeply entrenched in historical legacies and power imbalances, continues to impede the full potential of global health partnerships. It is imperative to transcend mere rhetoric and embrace a human-centric model that prioritizes equity, trustworthiness, and mutual respect.

The report challenges the conventional notion of *partnerships* and advocates for a more holistic view that recognizes the complexities and power dynamics inherent in these collaborations. It emphasizes the need to reimagine global health partnerships based on equity, not only as a moral imperative but also as a strategic necessity to unlock the full potential of collaboration and address complex health challenges effectively. The report concludes that fostering effective equitable global health partnerships necessitates not only awareness of diverse worldviews and effective communication but also a foundation of humility and adaptability. Embracing these principles can lead to truly transformative partnerships, promoting genuine collaboration; mutual respect; and, ultimately, improved health outcomes for all.

Conclusions and Recommendations

The following table visually presents a succinct version of the Committee's major conclusions and recommendations. Some additional information follows the table.

CONCLUSIONS	RECOMMENDATIONS
1. Global health funding is inherently complex due to diverse partners, priorities, and power imbalances	1. Promote transparency about financial incentives and constraints, and address funder dependence.
2. Harmonization efforts in global health can inadvertently perpetuate inequities and hinder systemic change.	2. Embrace contextual understanding and flexibility, foster collaboration and shared ownership.
3. Capacity building should move beyond a deficit-based approach, recognizing existing strengths and self-determination	3. Shift from capacity building to capacity strengthening, prioritize local ownership and knowledge exchange.
4. The pursuit of equity in global health necessitates acknowledging the interconnectedness of humanity	4. Cultivate mutual understanding, trustworthiness, and shared decision-making.
5. Effective communication, humility, and adaptability can enable truly transformative partnerships	5. Establish clear communication channels, cultivate a culture of openness and humility, prioritize emotional intelligence and empathy, and embrace power-sharing.
6. Humility—acknowledging limits, embracing uncertainty, and adapting to change—holds the key to equitable global health partnerships.	6. Practice active self-reflection and vulnerability, cultivate a learning and growth mindset, and embrace decolonial perspectives and practices.

CONCLUSIONS EXPANDED

Conclusion 1: The complexities of global health funding, with its diverse partners, competing priorities, and inherent power imbalances, are deeply embedded in the current landscape.

Conclusion 2: The pursuit of harmonization in global health partnerships, while well-intentioned, can inadvertently perpetuate inequities and hinder long-term systemic change.

Conclusion 3: The concept of capacity must evolve beyond a deficit-based approach, from capacity building to capacity strengthening. Global health partnerships need to embrace the knowledge, agency, and resilience of communities, recognizing their existing strengths and prioritizing their self-determined agendas.

Conclusion 4: The pursuit of equity in global health necessitates acknowledging the interconnectedness of humanity. Openness and curiosity, even amidst difficult truths, position individuals and organizations to foster equity in their global health relationships.

Conclusion 5: Fostering equitable global health partnerships necessitates not only awareness of diverse worldviews and effective communication but also a foundation of humility and adaptability. Embracing these principles can enable truly transformative partnerships, promoting genuine collaboration; mutual respect; and, ultimately, improved health outcomes for all.

Conclusion 6: Humility—acknowledging limits, embracing uncertainty, and adapting to change—holds the key to equitable global health partnerships. It cultivates collaboration, builds trust, incentivizes trustworthiness, and ultimately drives equitable and sustainable outcomes in global health endeavors.

RECOMMENDATIONS EXPANDED

Recommendation 1: Participants in a global health partnership should proactively acknowledge and address financial incentives and constraints that shape decision-making, to promote transparency and open dialogue. Overcoming dependence on external funders should

form part of regional dialogues and practices to balance power in global health partnerships.

Recommendation 2: Individuals and organizations alike should actively seek to understand the diverse contexts and perspectives of their partners; embrace flexibility, recognizing that standardized approaches may not always be appropriate or effective; and foster genuine collaboration and shared ownership.

Recommendation 3: Global health partnerships should shift from capacity building to capacity strengthening. Specific capacity-strengthening practices include

- prioritizing local ownership, ensuring that communities play a central role in defining their health priorities and leading capacity-strengthening initiatives;
- facilitating multidirectional knowledge exchange by creating opportunities for mutual learning and knowledge sharing and by valuing diverse perspectives and expertise, including traditional healing practices and indigenous knowledge systems;
- cultivating inclusive and transparent decision-making by establishing equitable governance structures that ensure meaningful participation and representation of all partners, particularly those from marginalized communities and low- and middle-income countries, in decision-making processes;
- fostering open communication about funding sources, allocation, and decision-making processes, ensuring that all partners have access to information and a voice in shaping the partnership's direction.

Recommendation 4: Those involved in a global health partnership should cultivate mutual understanding and trust and embrace shared decision-making. Specific practices to these ends include:

- co-creating goals, strategies, and evaluation metrics that reflect the collective aspirations and priorities of the partnership, which empowers all stakeholders and fosters a sense of ownership and commitment to shared outcomes;

- establishing open communication channels where partners actively listen, share perspectives, and acknowledge differing viewpoints; and
- fostering cultural humility by recognizing their biases and assumptions while valuing the knowledge and expertise of all stakeholders.

Recommendation 5: Organizations and practitioners in global health partnerships should cultivate a culture of openness and humility, prioritize emotional intelligence and empathy, and embrace shared decision-making and power-sharing. They should establish clear communication channels that encourage open dialogue and constructive feedback.

Recommendation 6: Organizations and practitioners in a global health partnership should actively cultivate self-reflection, vulnerability, and a learning mindset, embrace decolonial perspectives, and decenter dominant narratives.

Implementing these recommendations will promote a future in which global health partnerships are truly equitable, empowering all stakeholders and contributing to a more just and sustainable global health landscape.

1
Background and Context

The current era, characterized by complex and interconnected health challenges, presents a unique opportunity for global health partnerships to emerge as powerful agents of change. These collaborative endeavors, uniting diverse stakeholders from across the globe, can catalyze transformative change and enhance health outcomes universally. However, systemic inequities, deeply entrenched in historical legacies and power imbalances, continue to impede their full potential.

The present report serves as an unequivocal call to action, advocating for a paradigm shift in the approach to global health partnerships. It is imperative to transcend mere rhetoric and embrace a human-centric model that prioritizes equity, trustworthiness, and mutual respect among all involved in these partnerships. Practices that foster transformative learning, cultural awareness, and humility support genuinely collaborative partnerships that empower all stakeholders and contribute to a more just and sustainable global health landscape.

This report adds to the work of other scholars and practitioners who have, for example, focused on the following:

- All actors working together to achieve universal health care (Lal et al., 2021; Witter et al., 2023)
- Language and communicative practices (Sewankambo et al., 2023; Spiegel et al., 2015)
- Ethical short-term medical missions (Lasker et al., 2018; Prasad et al., 2022)
- Strengthening global solidarity and health security (Assefa et al., 2021; Lal et al., 2021)

The report underscores the interconnectedness of various factors that influence equity in global health partnerships. It delves into the complexities of power dynamics, historical legacies, and

diverse perspectives shape these collaborations. The committee's recommendations offer invaluable insights and actionable steps toward cultivating a more equitable and sustainable global health ecosystem. Each section provides practical guidance for both global health practitioners and organizations engaged in global health partnerships. The committee's overarching aim is to facilitate the realization of a global health landscape that is not only effective but also inherently just and equitable.

BRIEF HISTORY OF GLOBAL HEALTH PARTNERSHIPS

Equity has long featured in global development discourses. As early as the establishment of the World Health Organization in 1948, agenda-setters discussed various arrangements intended to promote inclusive decision-making and justice. The idea of social justice was touted as part of the 1978 Alma-Ata Declaration, which promoted Health For All (i.e., universal primary health care). And scholars of the era provided ample evidence of the need for multisectoral and inclusive partnerships (see, e.g., Amisi et al., 2023; Farrell et al., 2023; Plamondon et al., 2021).

Since the beginning of this millennium, global, regional, national, and community-level actors have realized the centrality of partnerships to achieving international development goals, including those that focus on global health. The United Nations' Millennium Development Goal 8 (MDG8), "develop a global partnership for development," and Sustainable Development Goal 17 (SDG17), "partnerships for the goals," represent a crucial evolution in the understanding of global development cooperation (Fukuda-Parr & Hulme, 2011; Sachs, 2012). While MDG8 focuses primarily on establishing a global partnership for development, SDG17 broadens this scope, emphasizing the necessity of revitalized and inclusive global partnerships to achieve all the SDGs (Cruz, 2023; Feeny, 2020). This shift underscores the recognition that the challenges of the 21st century, from poverty eradication to climate change mitigation, require collaborative and multistakeholder approaches that transcend traditional aid paradigms (Sachs, 2012).

Global health partnerships—of differing scales, scope, values, motives, motivations, resource levels, geographic reach, influence, impact, and years in operation—have become indispensable components in addressing the multifaceted challenges that transcend national borders (Frenk & Moon, 2013). These collaborative arrangements, which bring together a diverse set of actors, including governments, international organizations, nongovernmental organizations, academia, and businesses, remain crucial to delivering global public goods for several reasons. First, partnerships leverage the strengths and resources of various stakeholders, enabling a more comprehensive and coordinated response to complex health issues (Buse & Hawkes, 2015; Kaul et al., 1999; Ramalingam & Kumpf, 2021). Second, they facilitate knowledge sharing, technology transfer, and capacity building, empowering local communities to address their health needs effectively (Brousseau & Glachant, 2008; Ramaswamy et al., 2016; Wenham et al., 2019). Third, partnerships foster innovation and promote the development of new solutions and interventions that would not be possible in isolation (Szlezák et al., 2010; Yamey et al., 2020). Finally, partnerships are critical for mobilizing financial resources, advocating for policy changes, and creating a sustained impact on global health outcomes (Atun, 2012; Ostrom, 2015; Kickbusch et al., 2020). Although one could imagine many other benefits of global health partnerships, those outlined here provide a launchpad for this report.

In this report, the committee focuses mainly on macrolevel partnerships that connect bilateral donors, foundations, and public entities in multifaceted global health projects with a wide reach. The committee also acknowledges the many forms of global health partnerships, including those that happen at community, district, subnational, country, regional, and continental levels. While any number of partnerships can emerge at those levels, this report does not analyze them in detail. That said, all global health practitioners and partnerships can adapt the recommendations in this report to fit their circumstances.

PAST SUCCESSES OF GLOBAL HEALTH PARTNERSHIPS

Although the examples presented in this report are imperfect, they illustrate progress toward equitable global health partnerships. The committee recognizes the inherent complexities and nuances of such collaborations and understands that different contexts shape perceptions of success, improvement, and justice. We encourage readers to approach these examples with a discerning eye, focusing on the positive strides these organizations and initiatives have made toward fostering equity, while also remaining cognizant of the ongoing challenges and areas for further growth.

The power of global health partnerships is evident in numerous success stories from around the world. In Africa, the Roll Back Malaria Partnership has made significant strides in reducing malaria-related mortality and morbidity through collaborative efforts in prevention, treatment, and research (Kuecken et al., 2020; Steketee & Nahlen, 2017). Gavi, the Vaccine Alliance, has played a crucial role in increasing immunization coverage in low- and middle-income countries, contributing to the decline of vaccine-preventable diseases (Ikilezi et al., 2020; Jaupart et al., 2019). Gavi has also gone to great lengths to create markets for new and underused vaccines for diseases endemic to the countries it serves. The Advanced Market Commitment framework for several vaccines (e.g., pneumococcal, MenAfriVac, HPV, rotavirus, COVID-19 vaccines through the COVAX facility) has accelerated vaccine uptake in countries that needed the vaccines but were unable to provide the necessary market for pharmaceutical companies to produce them (MacLennan & Saul, 2014; Zhu et al., 2024). In Asia, the Stop TB Partnership has catalyzed efforts to combat tuberculosis through innovative approaches and strong advocacy (Creswell et al., 2020; Mwaba et al., 2011; Uplekar et al., 2015). The Global Fund to Fight AIDS, Tuberculosis and Malaria has supported numerous countries in scaling up their HIV/AIDS, tuberculosis, and malaria programs, saving millions of lives (Kates et al., 2019). In South America, the Pan American Health Organization has facilitated

regional cooperation on health priorities, including the response to the COVID-19 pandemic (Freitas et al., 2020; Nardi et al., 2023).

The following examples showcase other relevant national-level partnerships. While they have many strengths, these examples still need to make improvements toward equity. The examples are listed by region, with more detail provided in Box 1 on a partnership in Ireland.

Asia

Global Enteric Multicenter Study (GEMS): This landmark research endeavor sought to identify the leading causes of moderate-to-severe diarrhea in children from developing countries. The study involved a vast network of researchers across Asia, Africa, and South America, including prominent contributors such as Dr. Gagandeep Kang from India and Dr. Samba Sow from Mali (Kotloff et al., 2013). GEMS's findings have significantly influenced diarrhea prevention and treatment strategies worldwide.

Immunization coverage: In India, through partnerships such as Gavi, the Vaccine Alliance, three-dose immunization coverage for diphtheria, pertussis, and tetanus (DPT3) increased from 61% in 2000 to 91% in 2021 (Ikilezi et al., 2020). This significant rise reflects improved access to vaccines and strengthened health care systems, showcasing the impact of collaborative efforts.

Tuberculosis treatment success rate: In Cambodia, equitable partnerships with organizations such as the Stop TB Partnership have contributed to a remarkable increase in the treatment success rate for drug-resistant tuberculosis, from 35% in 2000 to 81% in 2020 (Creswell et al., 2020). This demonstrates the transformative potential of partnerships in tackling complex health challenges through innovative approaches and knowledge sharing.

Africa

African Malaria Network Trust (AMANET): AMANET is a pan-African research consortium dedicated to combating malaria through collaborative research and capacity building. Researchers

from various African institutions, such as Dr. Abdoulaye Djimde from Mali and Dr. Dyann Wirth from the United States, have collaborated within AMANET to investigate malaria drug resistance and develop new antimalarial interventions (Kilama et al., 2007; Nyika et al., 2010)

The KEMRI-Wellcome Trust Research Program: This long-standing partnership between the Kenya Medical Research Institute (KEMRI) and the Wellcome Trust has produced groundbreaking research on various infectious diseases, including HIV, tuberculosis, and malaria. Kenyan scientists such as Dr. Kevin Marsh and Dr. Bernhards Ogutu have played central roles in this collaboration, leading research on malaria vaccine development and epidemiology (Marsh et al., 2008; Simiyu et al., 2010).

Malaria mortality reduction: In sub-Saharan Africa, concerted efforts through the Roll Back Malaria Partnership have resulted in a substantial decline in malaria mortality rates. Between 2000 and 2020, malaria deaths decreased by 60%, showcasing the significant impact of collaborative efforts in prevention, treatment, and vector control (Kuecken et al., 2020).

HIV treatment coverage: In South Africa, equitable partnerships with organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria have facilitated a dramatic increase in HIV treatment coverage. The percentage of people living with HIV receiving antiretroviral therapy rose from less than 5% in 2000 to 62% in 2017, significantly improving the quality of life and life expectancy for those affected (Naqvi et al., 2023; Zuma et al., 2022).

South America

The Oswaldo Cruz Foundation (Fiocruz): Fiocruz, a renowned Brazilian research institution, has engaged in numerous international partnerships to address health challenges in South America and beyond. Researchers such as Dr. Margareth Dalcolmo and Dr. Wilson Savino have collaborated with colleagues from across the globe on projects related to tuberculosis, HIV/AIDS, and emerging infectious diseases (Almeida, 2010; Ferreira et al., 2016; Roa & Silva, 2015).

Research funding for Neglected Tropical Diseases: The international partnership with the Bill and Melinda Gates Foundation to finance NTD research, such as in the Brazilian Tuberculosis research Network (RedeTB) and World Mosquito Program, whose results have advanced the National Health System. One of the achievements of the RedeTB is the incorporation of the Xpert MTB/Rif test into the National Health System, which is used to diagnose more than 60% of tuberculosis cases in Brazil. (Dujardin et al., 2010; Melo et al., 2023).

Maternal mortality reduction: In Peru, collaborative efforts with international and non-governmental organizations have led to a substantial reduction in maternal mortality. The maternal mortality ratio decreased from 185 deaths per 100,000 live births in 1990 to 60 deaths per 100,000 live births in 2017, reflecting improvements in maternal healthcare access and quality (Kohler-Smith et al., 2019; Samuel, 2016).

Chagas disease control: In Brazil, equitable partnerships have facilitated progress in controlling Chagas disease. The seroprevalence of *Trypanosoma cruzi* infection in children aged 1–5 years decreased from 4.2% in 1990 to less than 1% in 2010, highlighting the impact of collaborative vector control and improved diagnostics (Dias et al., 2002; Moncayo, 2003).

These examples illustrate the crucial contributions of researchers and practitioners from Asia, Africa, and South America to global health research partnerships. Their involvement highlights the importance of fostering collaborative networks that harness diverse expertise and perspectives to tackle complex health challenges worldwide. In the final analysis, these examples demonstrate the transformative potential of partnerships in improving global health outcomes.

Additionally, quantitative examples demonstrate the tangible and measurable benefits of equitable global health partnerships in addressing various health challenges across different regions. By fostering collaboration, knowledge sharing, and resource

BOX 1
ESTHER Ireland Partnerships

Applying the European ESTHER Alliance partnerships model, ESTHER Ireland fosters effective partnerships to strengthen health systems, and in particular human resources for health, to improve the quality and safety of health care.

ESTHER Ireland uses two approaches to supporting health partnerships. First, it identifies and approves ESTHER Ireland Partners. These are health partnerships between Irish institutions and counterparts in the Global South that are well established and demonstrate the highest quality assessed through an audit and interview process. Second, it supports the early development or formalization of health partnerships between Irish institutions and those in the Global South with advice, training, and small seed funding to enable the initial reciprocal steps towards establishing a partnership—for instance, support for partnership visits to develop a shared vision and a joint understanding and commitment.

These partnerships have made a significant contribution to health outcomes in the Global South by addressing inequities in access and coverage while improving the quality of services through capacity building and institutional development. A case among many is the Muhimbili National Hospital—Our Lady's Children's Hospital Crumlin Partnership in Tanzania. In June 2004, Tanzania's first cancer ward for children was opened at the Ocean Road Cancer Institute (ORCI). At the time, the provision of cancer services for children was low, and in 2005 long-term survival rates for children attending the ward at ORCI were estimated at less than 20% and less than 5% across the country as a whole. Thanks to the greater provision of specialized training for local professionals and access to state-of-the-art diagnostic services, long-term child cancer survival rates among patients attending Muhimbili National Hospital have increased to 50% in just over 10 years.

SOURCE: Macdonald et al., 2016.

mobilization, these partnerships have the power to drive significant improvements in health outcomes and contribute to a healthier and more equitable world.

The preceding background notwithstanding, these partnerships include a diversity of structures and legal arrangements, but they

nearly always include multiple organizations headquartered in different countries and with varying engagements across the globe. Partnerships typically include funding organizations primarily from the Global North, implementing organizations, multilateral entities, research institutions, and businesses. No matter the organizational reach, size, influence, or scope, partnerships involve intricate legal details, human relationships, financial arrangements, organizational priorities, and often conflicting motivations for partnering. The committee understands the various relationships that exist under the banner of global health partnerships. This report does not delve into the manifestations of partnerships; rather, it focuses on actions and attitudes of the individuals who work within different types of global health partnerships.

2
Problem Statement and Opportunity

This chapter relays both the problems and the opportunities present in the current landscape of global health partnerships. It acknowledges the systemic inequities that persist in the foundations and structures that undergird these partnerships. And it presents for a model for addressing these inequities to promote health, equity, and development. Next, the chapter points out the opportunity and urgency of the present moment for transforming global health partnerships. In that context, it concludes by describing the purpose of the study.

SYSTEMIC INEQUITIES PERSIST

With less than 6 years remaining to achieve the United Nations' Sustainable Development Goals (SDGs), SDG17 serves as a powerful reminder to intensify our efforts toward equitable and inclusive partnerships. Such partnerships are essential for realizing ambitious development goals at all levels, including health. While global health partnerships have undoubtedly contributed to significant progress, the persistence of systemic inequities continues to hinder their full potential (Abimbola et al., 2021; Harris & Pamukcu, 2020). These inequities are not isolated incidents but are deeply ingrained within the structures and power dynamics of these collaborations, perpetuating historical and ongoing patterns of disadvantage that disproportionately affect marginalized populations and low- and middle-income countries (Spicer et al., 2020). Systemic inequities manifest in various ways across different regions, further undermining the effectiveness of global health initiatives. These manifestations of systemic inequities—namely, power imbalances, resource disparities, and skewed knowledge production and ownership—highlight the urgent need for transformation in global health partnerships.

Power Imbalances

Power imbalances often result in decision-making processes that favor high-income countries and powerful organizations, limiting the influence of partners in the Global South (Crane, 2013; Ramaswamy et al., 2016), and leaving less affluent partners with limited influence (August et al., 2022; Crane, 2013; Ramaswamy et al., 2016). For example, in the context of vaccine development, pharmaceutical companies from the Global North often hold significant control over research priorities and intellectual property rights, limiting the ability of partners in the Global South to shape agendas or access affordable vaccines (Benavides, 2022; Fonseca et al., 2021).

Resource Disparities

Resource disparities persist, with financial and technical resources flowing disproportionately to wealthier partners, hindering capacity building and sustainable solutions in resource-constrained settings (McCoy et al., 2021). This is evident in the case of malaria control in Africa, where, despite advancements through partnerships (e.g., African Malaria Network Trust), remote and marginalized communities often lack the resources to access essential preventive measures and treatments, resulting in ongoing health disparities (Mills et al., 2008; Mwenesi et al., 2022).

Skewed Knowledge Production and Ownership

Skewed knowledge production and ownership can reinforce existing knowledge hierarchies, leading to the neglect of local knowledge and priorities (Evans et al., 2014; Feierman et al., 2010). Research partnerships can reinforce existing knowledge hierarchies, with research priorities and methodologies often dictated by institutions in high-income countries (Evans et al., 2014; Feierman et al., 2010). This can be seen in the criticism faced by the Kenya Medical Research Institute (KEMRI)-Wellcome Trust Research Programme for its limited capacity-building efforts and knowledge transfer to local communities, raising concerns about the

sustainability of its impact and the equitable distribution of benefits from research (Molyneux et al., 2021).

Further examples of systemic inequities include the following:

- Africa: The Global Fund, while successful in combating HIV/AIDS, tuberculosis, and malaria, has been criticized for its complex funding application process and reporting requirements, which can be burdensome for resource-constrained countries (Sekalala & Kirya, 2013; Taylor & Harper, 2014).
- South America: During the COVID-19 pandemic, wealthier populations in South America had greater access to vaccines and health care resources, while marginalized communities faced significant barriers, highlighting persistent inequities in health systems (Boschiero et al., 2021; Castro-Nunes & Ribeiro, 2022).

These examples underscore the urgent need to address systemic inequities within global health partnerships to ensure that the benefits of collaboration are shared equitably and that the goal of achieving health for all is truly realized. Addressing inequity in global health partnerships requires challenging power imbalances, promoting fair and transparent resource allocation, and ensuring meaningful participation and ownership by communities in the Global South. It will require addressing the very foundations of global health structures and systems, where enduring inequities are rooted.

ADDRESSING SYSTEMIC INEQUITIES

Early and current leaders in the global health arena have done important work regarding such key issues as institutional structures, financial flows, communicative practices, and agenda setting. All of these are important aspects of fair global health partnerships. An enormous body of scholarly work has offered new perspectives and options to promote equity.

However, the committee suggests that the future of equity in global health partnerships lies in upending the way discourse on

equity informs action. The committee envisions a discourse where hegemonic global health systems and structures coevolve with those on the periphery of power and money to produce and sustain a better foundation, allowing for the reimagining and rebuilding of global health structures and systems.

Biases and recurring patterns in the following areas reveal how the current system reproduces and sustains inequities (see Figure 1):

- Relationships with one another
- Getting things done (what matters and to whom)
- Learning, change, and development.

This model highlights the messiness of social phenomena. Nothing and nobody is perfect, least of all relationships, which are complex and dynamic because they are interdependent with what humans do and how they change and grow. The possibilities for equity start with the recognition that all components depend on one another to build better and more effective relationships that promote health outcomes.

Each of these areas build on current scholarship by focusing on traditionally marginalized voices from the Global South. This process of reorientation reveals the inadequacies or blind spots of conventional thinking in global health circles while simultaneously challenging actors in the Global South to consider the ways their thinking and actions affect their emancipation.

This report reviews evidence on relationality in global health partnerships, power, and development, showing patterns of behavior, structures, and systems that embed inequities within global health partnerships. The committee intentionally reframes partnerships as holistic and complex relationships, and it calls on partners in the Global South to claim power.

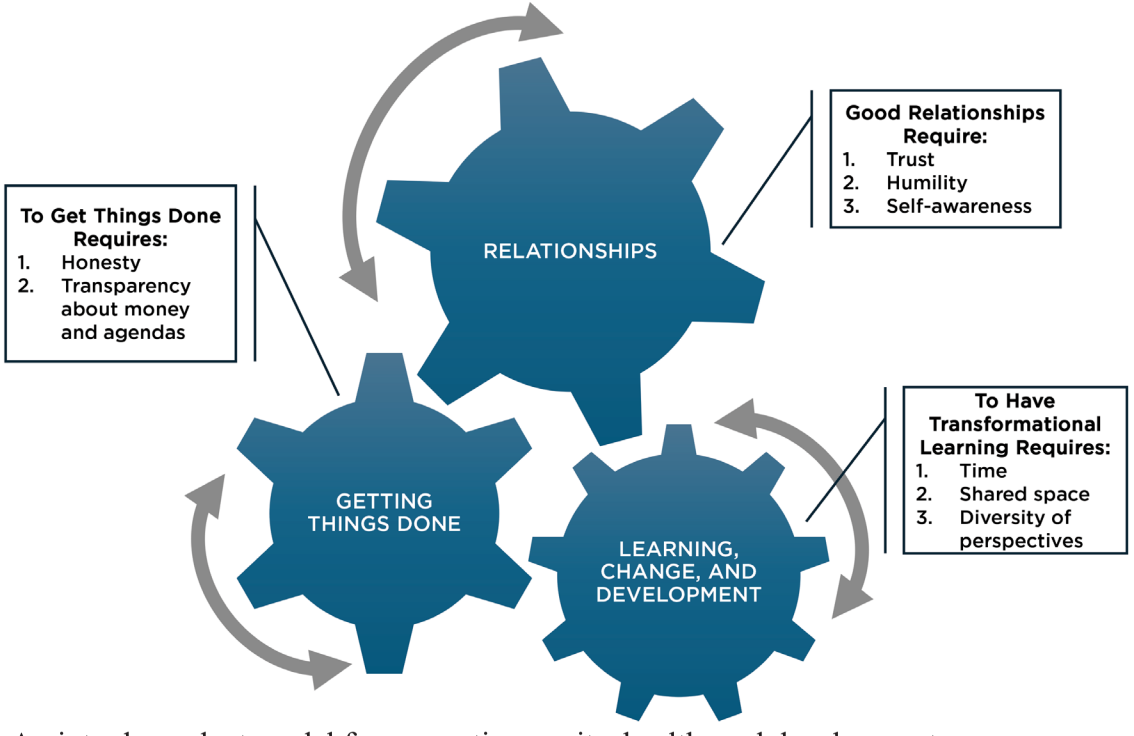

FIGURE 1 An interdependent model for promoting equity, health, and development.
Source: Generated by the committee.

Holistic and Complex Relationships

This study problematizes the notion of "partnerships" as typically and ubiquitously used in global health. So-called partnerships are established without articulating the motives of each partner. In the end, partnerships become legalistic and a replica of a dominant, powerful partner's view of partnerships. Instead, a more holistic view is needed: partnerships can provide unprecedented opportunities for learning, co-creating solutions, and implementing programs that uplift humanity.

The current global health architecture, deeply rooted in global political and socioeconomic systems, perpetuates inequities not only between the Global North and South but also within and among South–South partnerships. However, the aim is not to assign blame to any particular region or entity for these persistent disparities. Rather, this moment presents an opportunity to engage in more prospective and responsible dialogue and practices. True value and relevance lie in equitable global health partnerships that empower all parties involved, rather than favoring one side over another. Inequities at the macro level, among institutions and nations, cascade down to the micro level, impacting local communities and individuals. This study seeks to address the complex and ever-evolving relationships within global health partnerships, particularly where power struggles exist, with a clear emphasis on ensuring that the Global South stands on an equal footing in shaping these collaborations.

Fair and balanced partnerships, where everyone involved benefits, give rise to valuable and meaningful outcomes in global health. This study aims to understand and navigate the messy, complex, and power-laden relationships within global health partnerships, particularly in contexts where power struggles persist.

Claiming Power

The Global South has innate agency and power to reframe global health partnerships for the benefit of the world. The status quo will continue to create inequitable global health relationships if the Global Majority does not take charge of the future. Allies in the minority (the Global North) will serve a critical role in challenging

the prevailing power imbalances in global health partnerships. How allies across divides relate to each other will determine how well they engage in foresight activities to co-create global health partnerships that place a premium on equity in practice.

THE OPPORTUNITY

While global health partnerships continue to grapple with systemic inequities, interconnected threats—such as emerging infectious diseases, climate change, and antimicrobial resistance—create urgency and a unique opportunity for transformative change. These challenges underscore the necessity for equitable and collaborative solutions for ensuring well-being for communities around the globe (Wenham, 2021). At this critical juncture, the potential of partnerships can be harnessed to build a more just and resilient global health landscape.

The past successes of partnerships in tackling major health crises, such as HIV/AIDS and COVID-19, serve as beacons of hope. These collaborative efforts, to varying extents, have demonstrated the power of collective action in developing vaccines, scaling up treatment programs, and strengthening health systems (Amos et al., 2023; Sheikh et al., 2016). This point does not negate the experiences of vaccine hoarding and travel restrictions (which often ignored vaccination status) of passengers from the Global South to the Global North. Nonetheless, these achievements can point the way to a new era of global health partnerships that prioritize inclusivity, equity, and shared prosperity. The current threats to global health present an opportunity to reimagine global health partnerships, ensuring that the benefits of collective action reach the most vulnerable populations and contribute to a healthier and more equitable world for all. See Box 2 for one organization's efforts to implement ethical principles in global health partnerships.

BOX 2

Guiding Principles for Conducting Global Health Activities

The Catholic Health Association (CHA) of the United States issued the Guiding Principles for Conducting Global Health Activities in 2015. These six guidelines are helping Catholic-sponsored health ministries navigate the emotions and goodwill of global health activities with in a way that can ensure that good intent creates good outcomes for all involved in a partnership. The guidelines, offered to help Catholic health care most appropriately conduct international programs, bring to life the richness of Catholic social teaching and tradition. They are based loosely on the "Oath for Compassionate Service" in the book *Toxic Charity* by Robert Lupton and on insights from a special workgroup CHA convened to examine current international health program practice in light of its ministry's commitments.

The principles include:

1. Prudence—Good judgment requires controlling our enthusiasm to do good so that we also do it well, even in times of emergency.
2. Authenticity—Know thyself, know thy partner.
3. Honesty—Meaningful partnership requires a high level of trust and multiple lines of communication.
4. Patience—The process of getting to know your partner to build capacity often takes longer than expected and requires patience.
5. Excellence—Something is not always better than nothing; low-resource settings do not permit lower standards.
6. Humility—We all have something to learn.

SOURCE: Catholic Health Association of the United States, 2022.

THE PURPOSE OF THIS STUDY

There exists today a unique opportunity to vivify equity in global health partnerships. This opportunity hinges on transforming the very nature of relationships among actors within these partnerships. By focusing on practical ways to humanize these relationships, we can cultivate the foresight needed to reframe and restructure global health collaborations for the betterment of all. The call

for *accompaniment*, where partners walk alongside each other in solidarity and mutual respect, emphasizes genuine collaboration and shared commitment to social justice in global health (Farmer, 2008; see also Parker & Kingori, 2016; Faure et al., 2021; O'Laughlin, 2016).

The demand for this transformation is palpable and widespread, and the capability and foundations have been laid for transformative learning and foresight. However, entrenched mental habits, interests, and practices within the global health architecture impede such foresight. The committee therefore proposes an evidence-informed approach to relational learning, with an emphasis on changes in day-to-day relational attitudes and practices. Such an emphasis empowers actors who recognize the need to overcome inequities to become catalysts for change, even if they feel constrained by the complexities of the global health landscape.

The committee seeks to reimagine global health partnerships based on equity, not only because it is a moral imperative—it is also a strategic necessity. Embracing inclusivity and fairness can unlock the full potential of collaboration, harnessing diverse perspectives and expertise to tackle complex health challenges more effectively (Kulwicki, 2006; Kyobutungi et al., 2021). Equitable partnerships are key to ensuring human dignity, upholding the fundamental right to health, and showcasing the best of humanity's capacity for cooperation, care, and compassion. Equitable partnerships are also crucial to achieving sustainable improvement in health outcomes. It is time to move beyond rhetoric and translate the principles of equity into concrete action, fostering partnerships that truly reflect the interconnectedness and shared aspirations of our global community.

3
Conclusions and Recommendations

In this chapter, the committee presents six aspects of global health partnerships that need to be considered when seeking to realize a new ethic of equity. Building on findings from the study of these areas, the committee shares conclusions and resulting recommendations, along with supporting arguments and examples of partnerships that, albeit imperfect, are working toward equity. The aspects considered are funding and incentives, harmonization practices, capacity building and strengthening, embracing diverse perspectives, managing defensiveness, and developing humility.

FUNDING AND INCENTIVES

The prevailing practices in global health partnerships often prioritize short-term gains and transactional relationships, driven by the urgent need to secure funding and demonstrate immediate outcomes. This emphasis, while understandable, can inadvertently hinder the pursuit of long-term, systemic change and perpetuate power imbalances.

The positive impacts demonstrated by certain partnerships can obscure the background work on equity, trust, mutual learning, and humility necessary for those impacts to emerge. Some funding approaches set partnerships and collaboration as a conditionality, creating incentives for inequitable, circumstantial, and potentially ineffective partnerships. Mature organizations, predominantly located in the Global North, may have more resources to avoid these pitfalls, but they often focus more on investing in their core deliverables than on the relationships that underpin those deliverables. Especially for complex projects, proactive and early investments in relationships can save time, money, and stress; promote equity; and augment project outcomes.

Moreover, the complexities of funding mechanisms and the pursuit of financial resources often create dependencies and

reinforce power asymmetries between partners (Chang et al., 2021; Echt & Harle, 2024). This transactional mindset hinders genuine collaboration and shared ownership, ultimately limiting the effectiveness and sustainability of global health interventions.

The committee's exploration of this issue reveals a stark reality: the current discourse surrounding money and decision-making in global health partnerships perpetuates inequities (McCoy et al., 2021). The sensitive nature of financial discussions, often occurring behind closed doors, contributes to this reality. Additionally, the pursuit of harmonization, although intended to streamline processes, can inadvertently exacerbate these inequities by reinforcing existing power structures and overlooking partners' diverse needs and contexts.

The structural realities of funding cycles and power dynamics within global health partnerships can create significant challenges for less privileged partners, limiting their ability to challenge existing frameworks and fostering a sense of powerlessness (Cakouros et al., 2024; Voller et al., 2022). These realities lead to emotional tension and cognitive overload, hindering transformative learning and perpetuating inequities.

Conclusion and Recommendation

Conclusion 1: The complexities of global health funding, with its diverse partners, competing priorities, and inherent power imbalances, are deeply embedded in the current landscape.

We must acknowledge that these challenges defy easy or quick resolution. Instead of striving for an idealistic, immediate transformation, partnerships need to focus on fostering greater transparency and open dialogue.

Recommendation 1: Participants in a global health partnership should proactively acknowledge and address financial incentives and constraints that shape decision-making, to promote transparency and open dialogue. Overcoming the dependence on external funders should also constitute part of national and regional dialogues and practices to balance power in global health partnerships.

Transparent communication about funding sources, allocation, and the potential impact of these factors on priorities and relationships—confronting these realities head on—enables partners to build trust, mitigate conflicts, and create a more equitable and accountable model where all stakeholders have a voice. Only through such open communication and a shared understanding of the financial landscape can global health partnerships navigate these complexities and work towards truly sustainable improvements in health outcomes.

Actors in the Global South must remember that equity also depends on one's contribution. What the Global South contributes to global health partnerships needs to be counted and acknowledged, instead of the Global South always looking like a beggar. As well, the Global South is not necessarily always the "good actor" in partnerships1; knowing when actions from the Global South thwart positive intentions of a global health partnership is also necessary.

HARMONIZATION AND ITS DISPARATE COSTS

Harmonization, conceptualized as reducing transaction costs by establishing shared understandings and standards, facilitates smoother transactions and comparisons (Nabyonga-Orem et al., 2016). However, the power dynamics inherent in defining and implementing these standards often reflect existing inequalities. Historically, Western capitalist nations and institutions such as the International Standards Organization have wielded significant influence in shaping these practices, sometimes inadvertently serving their own interests (Abbott & Snidal, 2001; Khan & Milne, 2019; Santos, 2018).

Multilateral institutions, such as the World Trade Organization, despite being led by individuals from the Global South, face entrenched legacies that can hinder equitable reform (Koumparoulis, 2012; Mahutga, 2006). The high cost and limited perceived benefits of overhauling decades-old practices can deter attempts to address

1 The committee is aware of the scandals in the Global South that have brought various countries into disrepute. Although a thorough discussion of this issue would require another report, we thought it important to highlight this reality.

inequities, leading to a focus on expansion and appeasing powerful stakeholders rather than genuine transformation (Subacchi, 2008).

An example of the disparate costs of harmonization is standardizing education requirements for health care workers. While these standards are intended to ensure global competency, they can lead to a brain drain from poorer countries and an influx of less qualified personnel from wealthier nations (Kiwanuka et al., 2020; Marchal & Kegels, 2003; Najib et al., 2019). This unequal exchange perpetuates health disparities and undermines local capacity building.

Similarly, harmonizing financial management practices and institutional arrangements can create unintended consequences. While these structures aim to promote transparency and accountability, they can mask underlying power imbalances and perpetuate isomorphic mimicry, where organizations comply with standards on paper while resisting them in practice (Bano, 2022; Masocha & Fatoki, 2018; Narzetti & Marques, 2021).

Conclusion and Recommendation

Conclusion 2: The pursuit of harmonization in global health partnerships, while well-intentioned, can inadvertently perpetuate inequities and hinder long-term systemic change.

Addressing these challenges requires a critical examination of power dynamics, a commitment to genuine collaboration, and a willingness to embrace diverse perspectives and knowledge systems. Prioritizing equity and recognizing the interconnected costs and benefits of harmonization can foster partnerships that truly empower all stakeholders and contribute to a more just and sustainable global health landscape.

Recommendation 2: Individuals and organizations alike should actively seek to understand the diverse contexts and perspectives of their partners; embrace flexibility, recognizing that standardized approaches may not always be appropriate or effective; and foster genuine collaboration and shared ownership.

Equitable harmonization practices require that organizations and individuals be willing to adapt and be flexible; value local

knowledge and expertise; and strive to create partnerships based on mutual respect, trustworthiness, and shared decision-making. This shift from the norm involves actively listening to the voices of all partners, particularly those from marginalized communities, and ensuring that their perspectives are valued and incorporated into decision-making processes.

The Joint Learning Network highlighted in Box 3 exemplifies how to overcome some of the challenges discussed in this section using collaborative (or joint) learning. Beyond harmonization, collaborative learning seeks to solve problems collectively and co-create solutions that can then be adapted to a particular context. This approach values learning from others around the globe, without assuming an imposed "correct" way from outside those contexts.

BOX 3
Joint Learning Network for Universal Health Coverage

The Joint Learning Network (JLN) for Universal Health Coverage is an innovative, country-driven network of practitioners and policymakers from around the globe who codevelop global knowledge products that help bridge the gap between theory and practice to extend health coverage to more than 3 billion people.

All activities are prioritized, shaped, led, and cofacilitated by JLN member countries. Using a unique joint learning approach—that includes a combination of multilateral workshops, country learning exchanges, and virtual dialogue—JLN members build on real experience to produce and experiment with new ideas and tools to implement universal health coverage.

The JLN encourages flexible thinking, enabling practitioners to synthesize new knowledge into knowledge products—including tools, assessments, policy analysis frameworks, decision-making tools, implementation guidance, and case studies—that both serve the needs of the country participants who co-created them and become public goods for the global health community.

SOURCE: Joint Learning Network, 2021.

CAPACITY BUILDING RECONSIDERED

A conventional understanding of capacity in global health, often rooted in colonial legacies, prioritizes external expertise and overlooks existing strengths within communities, perpetuating inequities and hindering effective partnerships (Enuameh et al., 2014; Mbembe, 2017; Rabaka, 2009). This narrow perspective limits the integration of diverse worldviews and reinforces power imbalances.

The paradigm in global health needs to shift from capacity building to capacity strengthening, which involves a broad, ongoing process of strengthening abilities. This approach encompasses not only technical skills but also contextual understanding, strategic management, and long-term commitment (Milen, 2001), recognizing the diverse capacities and worldviews present in developing countries and challenging the dominance of Western models.

The Ebola and COVID-19 crises exposed the pitfalls of underestimating local capacity. Initial responses often neglected the contributions of local health care workers and community-led initiatives, perpetuating power imbalances and hindering effective interventions (Benton & Dionne, 2015; Blair et al., 2017; Hillier, 2015; Oleribe et al., 2015; Parker et al., 2019). These experiences, coupled with prevailing narratives that misrepresented Africa's capacity during COVID-19 (Atehortua & Patino, 2020; Ayodele et al., 2023), underscore the urgent need to shift paradigms. Recognizing and valuing diverse forms of capacity, including local knowledge, community resilience, and traditional healing practices, become paramount for equitable and sustainable outcomes (Abimbola et al., 2021; de Sousa Santos, 2015).

The following examples, although not representing perfect partnerships, demonstrate components of equitable collaborations where capacity strengthening takes precedence (see also Boxes 4 and 5):

- **Bolivia's community health worker program**: This initiative exemplifies a shift away from top-down models by recognizing and valuing the knowledge and skills of local community health

workers, leading to improved health care access in underserved areas (Perry et al., 2003; Rios et al., 2007).

- **Thailand's village health volunteer program**: By training and empowering local volunteers, this program strengthens primary health care services and improves health outcomes, highlighting the importance of leveraging existing community capacities and social capital (Kowitt et al., 2015; Tejativaddhana et al., 2020).
- **Malawi's Community Management of Acute Malnutrition Program**: This program's reliance on community volunteers and mothers to address acute malnutrition showcases the effectiveness of community-based interventions built on existing capacities, significantly reducing child mortality and morbidity (Kawonga et al., 2017; Maleta & Amadi, 2014).

BOX 4
Chiang Mai University and the University of Minnesota Partnership

For a couple of decades, Chiang Mai University (CMU) and the University of Minnesota (UMN) have partnered across various disciplines. It is in this context that a new partnership between two of the entities from the respective universities developed. The Research Institute for Health Sciences (RIHES)[a] from CMU and the Center for Global Health and Social Responsibility (CGHSR)[b] from UMN worked to codesign and implement a series of research projects in climate change and health.

Given that climate change and health is a complex area of research, RIHES and CGHSR use a deliberate process to identify researchers, with equal importance given to leadership (co–principal investigator) from each institution. The funding for these projects is shared equitably by the institutions, and the process integrates evaluation and monitoring.

The framework is an integrated blend of three domains: (1) 2-year CMU–UMN collaborative grants to establish a portfolio of research project(s) with potential for growth; (2) student engagement opportunities including but not limited to Fogarty Fellowship and institutional scholarships to inform mentorship for both CMU and UMN students heeding local contexts for global health research; (3) sharing expertise of research skills and grant writing, for long-term capacity building and knowledge translation among CMU and UMN researchers and students. None of the three domains is performed alone. The participation of graduate students and their influence on institutional research capacity are animated by the knowledge generation of research projects.

RIHES and CGHSR leadership are committed to an equitable decision-making model, one that is rooted in local needs, that the partnership is long term and aims towards creating capacity in young researchers in both institutions, that mentorship is equitable across the institutions, that the participants operate with humility and cultural sensitivity. The leadership of both institutions touch base periodically to ensure that these principles are adhered to.

[a] https://www.rihes.cmu.ac.th/en
[b] https://globalhealthcenter.umn.edu

SOURCE: University of Minnesota, 2023.

BOX 5
University of California, Los Angeles and the University of the Philippines Manila Partnership

An example of an academic partnership that sought to promote greater equity was the University of California, Los Angeles (UCLA) and the University of the Philippines Manila (UPM) partnership to strengthen research capacity in primary health care in the Philippines. The collaboration aimed to alter power dynamics and promote equity by adopting several approaches:

1. LMIC-initiated collaboration: Unlike traditional partnerships led by high-income countries, project needs and decision-making were primarily led by the low- and middle-income country (LMIC) institution (UPM), reversing typical power imbalances in agenda setting and financial decision-making.

2. Mutual goal setting and cultural bridging: UPM and UCLA set shared objectives and emphasized mutual cultural understanding as a fundamental step early in the project process. They developed the project goals and methodologies together to ensure sensitivity and relevance to the local context.

3. Capacity strengthening and local leadership: While the project used traditional capacity-building paradigms, UCLA sought to involve UPM in all stages, from data collection to policy formulation. UCLA's role was to provide expertise and technical support, while UPM led the project execution, promoting local ownership and sustainability.

4. Joint teaching and knowledge exchange: The partnership also included coteaching graduate courses and facilitating joint research, which sought to promote bidirectional transfers of knowledge and experience.

While this case study shows recent changes in approaches to partnerships within the academic sphere, it reflects the complexities of equitable partnerships in the continued usage of language such as capacity-building and the lack of intersectional analyses applied to exploring the qualitative data gathered. This case embraces equitable approaches and ideas while revealing opportunities to explore more deeply the thinking and language used to assess partnerships.

SOURCE: Aryal et al., 2023.

Conclusion and Recommendation

Embracing a broader understanding of capacity leads to more effective and sustainable global health partnerships. Prioritizing local ownership, participation, and capacity strengthening empowers communities to take charge of their health and well-being, contributing to a more equitable world.

Conclusion 3: The concept of capacity must evolve beyond a deficit-based approach, from capacity building to capacity strengthening. Global health partnerships need to embrace the knowledge, agency, and resilience of communities, recognizing their existing strengths and prioritizing their self-determined agendas.

Moving beyond a deficit-based approach entails recognizing and leveraging existing capacities within communities and institutions in the Global South. True empowerment lies in communities taking ownership of their capacity-strengthening processes. Partners need to adopt a supportive role, offering assistance and expertise only when requested. Acknowledging the unique expertise of all partners and fostering multidirectional capacity strengthening creates truly collaborative environments that promote mutual respect; shared responsibility; and, ultimately, more sustainable and impactful outcomes.

Recommendation 3: Global health partnerships should shift from capacity building to capacity strengthening. Specific capacity-strengthening practices include the following:

- prioritizing local ownership, ensuring that communities play a central role in defining their health priorities and leading capacity-strengthening initiatives;
- facilitating multidirectional knowledge exchange by creating opportunities for mutual learning and knowledge sharing and by valuing diverse perspectives and expertise, including traditional healing practices and indigenous knowledge systems;
- cultivating inclusive and transparent decision-making by establishing equitable governance structures that ensure meaningful participation and representation of all partners,

particularly those from marginalized communities and low- and middle-income countries, in decision-making processes;

- fostering open communication about funding sources, allocation, and decision-making processes, ensuring that all partners have access to information and a voice in shaping the partnership's direction.

EMBRACING DIVERSE PERSPECTIVES

Global health partnerships bring together individuals with varied worldviews, shaped by their unique experiences and cultural backgrounds (Benatar & Brock, 2021; Koltko-Rivera, 2006). These diverse perspectives, while valuable, can also lead to tensions and misunderstandings due to conflicting priorities and unspoken assumptions (Crane, 2013; Hofstede, 2001). Recognizing and addressing these underlying differences remain key for organizations and individuals to foster equitable and sustainable partnerships (Citrin et al., 2017; Eichbaum et al., 2020; Maher & Sridhar, 2020).

To navigate these complexities, institutions and global health practitioners must understand the interconnected factors that influence worldviews. These include philosophical and historical contexts, psychological biases, cultural and social norms, educational backgrounds, and personal experiences (Benatar & Brock, 2021; Koltko-Rivera, 2006). By examining these elements critically, particularly when contrasting perspectives intersect, partnering agencies can better understand the potential for conflict and create space for genuine dialogue.

One area where diverse perspectives prove crucial lies in challenging the dominance of Western-centric models in global health. For example, the assumption of a context-free world, prevalent in Western thought, can hinder the pursuit of equity (Labonté, 2016; Mignolo, 2011; Packard, 2016). Similarly, the historical legacy of colonialism can shape how parties to global health relationships perceive and value different approaches to health care, potentially

devaluing traditional medicine and hindering equitable partnerships (Das, 2020; Ndlovu-Gatsheni, 2014; Packard, 2016).

Embracing diverse perspectives also means recognizing the importance of collaboration and shared decision-making in health care. This approach challenges the traditional power dynamic between patients and providers, valuing both empirical evidence and lived experiences (Alderwick et al., 2021; Lekas et al., 2020). See Boxes 6 and 7 for examples of embracing diverse perspectives in practice.

BOX 6

The Tropical Health and Education Trust

For over 30 years, the Tropical Health and Education Trust (THET) has been working in partnership to strengthen health systems and build health workforce capacity in low- and middle-income countries (LMICs). At the center of its approach is the model of Health Partnerships, long-term relationships between U.K. and LMIC health institutions, which improve health services through the reciprocal exchange of skills, knowledge, and experience. They are rooted in an understanding that equitable relationships between health professionals across borders can benefit all involved.

THET facilitates relationships between individuals and institutions that are equitable and long-term and that deliver quality outcomes and mutual benefit, drawing on Principles of Partnership. These principles are grounded in the long experience of supporting the Health Partnership model, to develop the health workforce and strengthen the health system.

THET partners widely with health institutions, governments, the private sector, academia, and other nongovernmental organizations, recognizing that the greatest impacts are often achieved by collaborating across sectors. THET champions and supports the contribution of health professionals through programs, campaigns, and conferences, fostering learning and information exchange across the Health Partnership community.

Over the past 9 years, THET has partnered with over 130 National Health Service Trusts, Royal Colleges, and academic institutions. From reducing maternal deaths in Uganda to improving the quality of hospital care for injured children in Myanmar, THET works to strengthen local health systems and build a healthier future for all. THET has reached over 100,000 health workers across 31 countries in Africa and Asia in partnership with over 130 U.K. institutions.

SOURCE: Tropical Health & Education Trust, 2024.

BOX 7
One Health Approach

One Health, an interdisciplinary approach to health, provides another case study for complexities in equitable relationships. Within Latin America, One Health has seen substantial growth in popularity and application, in part because of the following:

1. Grassroots and community-based initiatives: Vulnerable populations have been included in seroprevalence surveys when considering the transference and movement of microorganisms in animal populations, better reflecting the complexities of their lived experiences. Other efforts include outreach by the Federal University of Espírito Santo to include local communities and other regional universities in their project applications and agenda development.
2. Educational programs and joint teaching: The demand for holistic skillsets within government and the private sector enable locally driven program development. Local ownership and needs are served by the academic institutions, creating positive feedback cycles that ensure that local structures promote this responsiveness to local needs and interests.
3. Regional networks and partnerships: The ease of translation of One Health contributes to its rapid adoption and spread in the region. With One Health chapters in Brazil, Columbia, and Chile, international dialogues attract greater buy-in and a sense of progress. At the same time, these One Health affiliated groups have established connections to multilateral actors such as the Pan American Health Organization, building linkages across multiple layers and levels of organization.

While the One Health approach reflects the necessity and possibilities of partnerships across different ways of thinking, it faces challenges in disrupting conventional ways of organizing and including stakeholders.

SOURCE: Pettan-Brewer et al., 2021.

Conclusion and Recommendation

Conclusion 4: The pursuit of equity in global health necessitates acknowledging the interconnectedness of humanity. Openness and curiosity, even amidst difficult truths, position individuals and organizations to foster equity in their global health relationships.

Recognizing the rich collection of perspectives in global health partnerships challenges stakeholders to move beyond the limitations of dominant narratives and embrace a more inclusive understanding of health and well-being. While diverse viewpoints can lead to tensions, they also offer invaluable opportunities for collaboration and shared decision-making, ultimately leading to more equitable and sustainable outcomes.

Across cultures and continents, philosophies echo the fundamental truth of shared existence. Ubuntu's "I am because we are," India's *vasudhaiva kutumbakam* (the world is one family), Confucianism's emphasis on harmonious relationships, Japan's concept of *amae* (interdependence), the Andean principle of *ayni* (reciprocity), and the profound interconnectedness revered by Amazonian indigenous groups all underscore the deep ties that bind humanity. Even in the capitalist, Western world, the notion of the "social contract" acknowledges reliance on one another for collective well-being.

These diverse philosophies serve as a reminder that inequitable practices, rooted in power imbalances and the pursuit of short-term gains, not only hinder progress but also erode the very fabric of this shared humanity. The COVID-19 pandemic, HIV/AIDS, Ebola, and countless other health crises serve as stark reminders that the health and well-being of peoples and cultures of the world are inextricably linked.

Embracing a collaborative approach that values diverse perspectives and lived experiences allows for transcending traditional power dynamics and fostering genuine partnerships. By challenging dominant narratives and creating space for open dialogue, trusting relationships emerge, honoring the dignity and agency of all individuals and communities.

Recommendation 4: Individuals involved in a global health partnership should cultivate mutual understanding and trust and embrace shared decision-making. Specific practices to these ends include:

- co-creating goals, strategies, and evaluation metrics that reflect the collective aspirations and priorities of the partnership, which empowers all stakeholders and fosters a sense of ownership and commitment to shared outcomes;
- establishing open communication channels where partners actively listen, share perspectives, and acknowledge differing viewpoints; and
- fostering cultural humility by recognizing their biases and assumptions while valuing the knowledge and expertise of all stakeholders.

MANAGING DEFENSIVENESS

This section underscores the inherent challenges in promoting equity within global health partnerships, particularly the natural defensiveness and opposition that often arise when critical discourses challenge prevailing worldviews. The Committee recognizes that awareness of potential inequities alone is insufficient; addressing them requires overcoming deeply ingrained human tendencies and behaviors that can obstruct progress toward equity (Kegan & Lahey, 2009; Summers & Smith, 2014).

Common Challenges in Critical Discourse

Discussions about equity in partnerships are rarely dispassionate, as they can provoke questions about reality, identity, morality, and sense of self, triggering various defense mechanisms (Stone et al., 2010; Rabaka, 2009). These mechanisms, though potentially beneficial for human survival, can also hinder open communication and shared understanding. Recognizing three intertwined dimensions

of discourse—truth, emotions, and identity—can help navigate these complexities effectively (Stone et al., 2010).

When discussing "what happened"—in other words, truth about events or actions—three common defense patterns emerge: the blame frame, the truth assumption, and the intentional invention (Harris & Pamukcu, 2020; Hentschel et al., 1993). The *blame frame* involves attributing fault to a single individual, while the *truth assumption* manifests as a belief in one's absolute correctness. The *intentional invention* occurs when individuals ascribe negative intentions to others' actions, often leading to reactive anger. These patterns can create a vicious cycle of defensiveness and hinder productive dialogue, especially when the perceived stakes are high (Bradley & Campbell, 2016; Sen, 2000).

Even when partners agree on the truth about what happened, disagreements can arise about the significance of events or who has been hurt. Emotional expression is complex and influenced by cultural contexts and individual experiences (Nwoye, 2017; Otis, 2019; Tomlinson et al., 2018). Suppressed or dismissed emotions can lead to cycles of emotional suppression and outbursts, impeding trust and collaboration (Bresman & Edmondson, 2022; Gallo, 2022). Marginalized populations may face additional challenges in expressing their emotions freely, fearing threats to their safety or survival (Tamale, 2020). These dynamics can create misunderstandings and hinder genuine solidarity between partners.

Human beings are inherently self-oriented, often interpreting communication through the lens of their own identity (Adams, 2005). This can lead to "all-or-nothing" thinking, where individuals perceive feedback as a judgment on their entire being. These interpretations, often unspoken, can trigger defensiveness and hinder open dialogue, particularly when individuals tie their self-worth to their moral righteousness.

These three intertwined conversations highlight why good intentions and words alone are insufficient for achieving equitable outcomes. Meaning is co-created among individuals, and shared understanding is particularly challenging when partners come from dissimilar backgrounds. Global health partnerships must actively

engage in honest conversations about truth, feelings, and identity to foster trust, uncover historical inequities, and create the conditions for a more just and equitable relationship that benefits all.

The persistence of rigid thinking in global health partnerships can be attributed, in part, to how individuals update and revise their mental models (Kegan & Lahey, 2014). The "immunity to change" phenomenon highlights how deeply held beliefs and assumptions can hinder adaptation, even when change is necessary. As the world rapidly evolves, a willingness to adapt is crucial for maintaining relevance and achieving meaningful impact.

Conclusion and Recommendation

Conclusion 5: Fostering equitable global health partnerships necessitates not only awareness of diverse worldviews and effective communication but also a foundation of humility and adaptability. Embracing these principles can enable truly transformative partnerships, promoting genuine collaboration; mutual respect; and, ultimately, improved health outcomes for all.

Recommendation 5: Organizations and practitioners in global health partnerships should cultivate a culture of openness and humility, prioritize emotional intelligence and empathy, and embrace shared decision-making and power-sharing. They should establish clear communication channels that encourage open dialogue and constructive feedback.

The following sections list specific actions that organizations and global health practitioners can take to manage defensiveness and fulfill the objectives in Recommendation 5.

Cultivate a Culture of Openness and Humility

Organizations

- Establish clear communication channels that encourage open dialogue and constructive feedback.

- Provide training on cultural humility, implicit bias, and effective communication to promote understanding and reduce defensiveness.
- Create safe spaces where individuals can express their perspectives and concerns without fear of judgment or retribution.
- Global health practitioners
- Actively listen to diverse perspectives and acknowledge the validity of different experiences.
- Approach conversations with humility and a willingness to learn from others.
- Acknowledge one's biases and assumptions and work to challenge them.

Prioritize Emotional Intelligence and Empathy

Organizations

- Encourage emotional expression and create an environment where individuals feel comfortable sharing their feelings.
- Provide training on emotional intelligence and conflict resolution to help individuals navigate challenging conversations.
- Foster a culture of empathy and support, recognizing that individuals may have different emotional responses to equity discussions.
- Global health practitioners
- Develop emotional self-awareness and actively manage one's emotions during challenging conversations.
- Practice empathy by seeking to understand the perspectives and emotions of others.
- Validate the emotions of others and avoid dismissing or minimizing their feelings.

Embrace Shared Decision-Making and Power-Sharing

Organizations

- Implement structures and processes that facilitate shared decision-making and distribute power more equitably.
- Ensure that marginalized voices and communities are meaningfully represented in decision-making processes.
- Regularly review and evaluate power dynamics within the partnership to address any imbalances.
- Global health practitioners
- Advocate for shared decision-making and actively seek input from all partners.
- Challenge traditional power dynamics and work to create a more inclusive and collaborative environment.
- Be willing to cede control and share power with others, particularly those from marginalized communities.

Foster a Learning and Growth Mindset

Organizations

- Encourage a culture of continuous learning and reflection.
- Provide opportunities for professional development and training on topics related to equity, diversity, and inclusion.
- Celebrate successes and learn from mistakes, fostering a growth mindset that embraces change and adaptation.
- Global health practitioners
- Engage in ongoing self-reflection and critical analysis of one's beliefs and assumptions.
- Actively seek opportunities for learning and growth, particularly in areas related to equity and social justice.
- Be open to feedback and willing to adapt one's approach as needed.

HUMILITY FOR TRANSFORMATIONAL LEARNING AND EQUITY

Even in partnerships where there is an awareness of diverse worldviews and responsiveness to issues of truth, emotions, and identity, the pivotal element that either enables or obstructs equity remains humility. In this context, *humility* is defined by a willingness to acknowledge limitations, embrace uncertainty, and adapt to changing circumstances (Bedi, 2021; Kegan & Lahey, 2014). It allows for a constant reevaluation of what is possible and fosters a learning environment conducive to transformative action.

The Role of Humility in Learning and Adaptation

Effective learning systems require both the systems themselves and the individuals within them to navigate uncertainty while maintaining a clear strategic direction. True humility involves an ongoing process of refining one's understanding of what can and cannot be changed in any given situation. It demonstrates wisdom in this regard and fosters open dialogue about future possibilities. This aligns with the concept of *transformational learning*, which emphasizes critical reflection and a willingness to challenge deeply ingrained assumptions (Mezirow, 2018).

Achieving clarity about the purpose of global health partnerships, at both personal and organizational levels, necessitates incremental risk-taking and continuous learning. This learning mindset is vital for individuals and institutions to adapt and evolve in response to a dynamic global landscape (Lave & Wenger, 1991; Senge, 2006). Prioritizing individual and institutional learning geared towards equity can help contextualize and implement recommendations for equitable partnerships in global health (Cakouros et al., 2024; Faure et al., 2021).

Humility Challenges Power Structures

This emphasis on humility has the potential to unlock new strategic possibilities and leadership approaches within global health

partnerships. While institutions naturally seek to preserve their advantages, rigidly adhering to such strategies in a rapidly changing world can lead to obsolescence (McGrath, 2013). The persistence of rigid thinking often stems from how individuals update and revise their mental models or worldviews (Kegan & Lahey, 2009).

The research underscores that individuals' varying levels of mental complexity significantly influence their interpretations of their work and responses to organizational change. Those with lower mental complexity often focus on immediate, concrete tasks and may resist changes that disrupt their established routines (Acciarini et al., 2024). In contrast, individuals with higher mental complexity can conceptualize their work within broader contexts, recognizing nuanced interconnections and long-term implications, making them more likely to embrace change as an opportunity (Bester, 2019; Militaru et al., 2023).

Understanding these differences in mental complexity is crucial for leaders to effectively manage organizational change. Those with lower complexity may require more structured guidance to navigate transitions, while individuals with higher complexity can take a proactive role in implementing change (Rönnqvist & Harhio, 2024). Tailoring approaches to communicate the rationale and benefits of changes empowers all team members to adapt and thrive amidst organizational evolution, highlighting the complexity of ensuring employee satisfaction during times of change (Kőkuti, 2024).

These insights resonate with perspectives from critical pedagogy and decoloniality, highlighting how education can empower individuals to critically engage with and transform their realities or reinforce existing power structures (Freire, 1970; Spivak, 1988). Decolonial scholars, such as Frantz Fanon (2004), have emphasized the detrimental effects of educational systems that perpetuate hierarchical values and suppress diverse perspectives. Such systems can lead to mental distress and hinder the pursuit of genuine equality.

These critical examinations have profound implications for global health practice. They underscore how colonial legacies and power imbalances can shape mindsets and obstruct progress toward equity. Critiques of "lack of political will" or "poor implementation"

in the Global South often overlook the complexities of historical and structural constraints, perpetuating a blame narrative that absolves colonial powers of responsibility (Mbembe, 2017; Santos, 2018).

Despite the many potential benefits of humility, imbalanced or misplaced humility can easily become a force that silences the voices of those who experience it and can point out inequities. Imbalanced humility within a partnership can derail its goals. If only one partner always leads with humility and the others remain egocentric, no genuine partnership exists. For humility to thrive within global health partnerships as expressed in this section, it cannot be taken for granted at any stage of a partnership's evolution. When humility becomes a buzzword, learning stops, and relational pathologies thwart any efforts toward equitable partnerships.

Humility Fosters Collaboration & Mutual Respect

Amidst these challenges, humility offers an opportunity for growth and change. By fostering open dialogue, embracing vulnerability, and cultivating a shared commitment to learning, global health partnerships can navigate these complexities and create a space for genuine collaboration and mutual respect. Humility, in this sense, becomes a cornerstone for building trust, recognizing and rectifying past injustices, and fostering a sense of shared ownership and responsibility (Markey et al., 2021; Or & Golba, 2023).

The examples below provided from Asia, Africa, and South America demonstrate how humility can take root in global health partnerships, leading to more equitable and sustainable outcomes (see also Box 8). It is through such humble and collaborative approaches that we can truly achieve a global health landscape that values the dignity and agency of all individuals and communities.

- **Asia**: In the context of maternal and child health programs in Bangladesh, BRAC, a prominent nongovernmental organization, has consistently demonstrated humility by prioritizing community participation and local knowledge in program design and implementation. This approach has led to greater program effectiveness and sustainability (Rahman et al., 2023).

- **Africa**: In South Africa, the Desmond Tutu HIV Foundation has exemplified humility in its approach to HIV prevention and treatment. By actively listening to the needs and concerns of the communities it serves, the foundation has developed innovative and culturally relevant interventions that have significantly impacted the lives of people living with HIV (Mendelsohn et al., 2018).
- **South America**: In Ecuador, the Andean Health and Development organization has worked alongside indigenous communities to address health disparities, recognizing and valuing their traditional knowledge and practices. This approach has fostered trust and led to culturally appropriate and sustainable health interventions (Mathez-Stiefel et al., 2012; Perry et al., 1999)

BOX 8
West African Health Organization

The West African Health Organization (WAHO, or Organisation d'Ouest Afrique Santé), an organ of the Economic Community of West African States, provides a unique example of a regionally driven entity that pools external funding and directs it to serve local and national interests. WAHO develops its own strategic priorities and then allocates funding accordingly via projects that are developed in collaboration with the local implementers. Funding is drawn from multiple external funders, while the health ministers of the region approve project plans annually.

Some of WAHO's work reflects its connection to local priorities. For example, it published a traditional medicines compendium to address widespread usage of traditional healing approaches while maintaining a neutral tone in its assessment. WAHO has made significant efforts to ensure local ownership, with some studies highlighting the extent to which processes of project development and implementation take a collaborative approach (Keita et al., 2022). The organization has won credibility both with implementers and decision-makers.

Nonetheless, WAHO faces criticisms in its ability to sustain collaborative exercises. For example, some studies criticize WAHO's response to the Ebola crisis of 2014–2015 as slow (Arunga et al., 2021). Several studies point out the value of harmonizing medical standards and education and improving coordination through WAHO, each showing different examples of how bilateral actors have channeled their work through the WAHO to the benefit of local and national actors (Arunga et al., 2021; Katz and Standley, 2019; Keita et al., 2022). As WAHO continues to build credibility as a partner both for local and international interests, it provides a compelling case study for exploring how equity will feature in its partnership approaches and sustain the collaborative spirit that its structures are intended to foster.

Conclusion and Recommendation

Conclusion 6: Humility—acknowledging limits, embracing uncertainty, and adapting to change—holds the key to equitable global health partnerships. It cultivates collaboration, builds trust, incentivizes trustworthiness, and ultimately drives equitable and sustainable outcomes in global health endeavors.

Recommendation 6: Organizations and practitioners in a global health partnership should actively cultivate self-reflection, vulnerability, and a learning mindset; embrace decolonial perspectives; and decenter dominant narratives.

The following sections list specific actions that global health practitioners and organizations can implement to foster humility and fulfill the objectives in Recommendation 6.

Global Health Practitioners

1. Practice active self-reflection and vulnerability: Regularly examine one's biases and assumptions, be willing to acknowledge limitations, and seek feedback from partners.
2. Cultivate a learning mindset: Approach challenges and uncertainties with curiosity and a willingness to learn and adapt. This learning mindset allows for a regular appraisal of how one practices humility.
3. Embrace decolonial perspectives: Actively challenge dominant narratives and power structures and recognize the value of diverse knowledge systems.

Organizations

1. Foster a culture of humility: Encourage open dialogue, constructive feedback, and a willingness to challenge existing power structures and assumptions. In so doing, the organization keeps track of how it understands and practices humility.
2. Prioritize learning and adaptation: Create a culture of continuous learning and adaptation, where challenges are seen as opportunities for growth.
3. Decenter dominant narratives: Value diverse knowledge systems and actively challenge practices that perpetuate inequities.

4
Concluding Message

The committee has produced a decidedly optimistic report amidst global health and development challenges on multiple fronts. Global health partnerships exist in a broad context and architecture that prioritize quantitative data to express results at the expense of the relational aspects considered in this consensus study. The committee does not wish to denigrate quantitative data; rather, it offers a complementary approach to deepening the meaning of those data.

Leaders of global health partnerships, operating at multiple levels, will determine how this complementarity comes to life. The committee has set out the ingredients of equitable and effective global health partnerships based on its current understanding of the evidence used in this study. The ingredients may change over time, but the courage to intentionally call into question relational pathologies while making the requisite adjustments resides in individual practitioners, organizations of varying sizes, and multiple contexts. Therefore, leadership starts with you, the reader, before it ever reaches the chief executives and boards.

The committee, with its aspirational tone, invites all audiences to suspend the taken-for-granted "reality" that currently dominates our engagement in global health partnerships. Nothing improves without change, even when it requires vulnerability and a critical assessment of how individuals and organizations enact leadership in delivering global public goods via collaborations. Contributing positively to humanity requires caring deeply and taking the requisite responsibility to engage in the messiness of our global health relationships.

APPENDIX 1
Committee Bios and Secretariat

BIOGRAPHICAL DETAILS OF COMMITTEE MEMBERS

M. OLADOYIN ODUBANJO is executive secretary of the Nigerian Academy of Science and chairman of the African chapter of the International Network for Government Science Advice. He also sits on the boards of The Conversation Africa and the Leprosy Mission Nigeria. Odubanjo is a public health physician and chaired the Association of Public Health Physicians of Nigeria (Lagos chapter) for 4 years.

GINA LAGOMARSINO is president and CEO of Results for Development (R4D), which centers change agents—public, private, and civil society leaders—and aims to improve upon traditional global development approaches. Lagomarsino has more than doubled R4D's annual revenues—from $20 million in 2015 to $50 million in 2022—and has also significantly expanded the organization's global presence, with activities in 26 countries, offices in 8 countries, and a network of partners and experts around the world. Throughout her career, Lagomarsino has focused on expanding health coverage to low-income populations. She helped galvanize energy and political will around a global push for universal health coverage by coordinating an early global task force convened by the Rockefeller Foundation and coauthoring a frequently cited 2012 *Lancet* article on universal health coverage. Prior to her work in global development, Lagomarsino spent a decade working to improve health systems in the United States. As senior health policy advisor to Washington, DC, mayor Anthony Williams, she designed and implemented a free public health coverage program serving low-income DC residents in partnership with the city's private hospitals and clinics. Before that, she was engagement manager at McKinsey & Company, where she advised senior executives of health insurance and hospital organizations on strategy and operations. Lagomarsino holds a

master's degree in business administration from Harvard University and a bachelor's degree in public policy from Stanford University.

BRUCE COMPTON is senior director of global health at the Catholic Health Association (CHA) of the United States. In this role, he leads the CHA Global Health Advisory Council. He advises members regarding best practices related to global health practice, equity, ethics, workforce, and solidarity with the global community. Compton supports members, partnering organizations, and the church in a global healing mission through research, education, consultation, and collaboration. He is a founding member of the Alliance for Global Health Partnerships and the Christian Health Asset Mapping Coalition. Before joining CHA, Compton founded Hospital Sisters Mission Outreach to improve the health and wellness of people across the globe through the responsible donation of medical supplies, equipment, and support services. Previously, he lived in Haiti, serving as director of administration and finance for the Haitian Health Foundation.

NELSON K. SEWANKAMBO is Ugandan professor of medicine at Makerere University College of Health Sciences and a health researcher. He was at the forefront of conducting consensus studies on owning our future on urbanization in Uganda, in East Africa, and in Africa as a whole. Sewankambo has a passion for advancing health workforce capacity development and addressing health inequities in Africa. In the 1980s, he was one of the earliest physicians to recognize the AIDS epidemic in Uganda that caused patients to lose weight severely. He was vice president of the Network of African Science Academies and is a fellow of the African Academy of Science, World Academy of Sciences, and Uganda National Academy of Sciences, and he is a fellow and external affiliate of the U.S. National Academy of Medicine.

EUNICE KARANJA KAMAARA is a professor of ethics with over 30 years of experience in transformative research for holistic health development. She holds a Master of Science in international health research ethics and a doctorate in African Christian ethics. She is passionate about mainstreaming gender, diversity, and inclusivity and translating research on character values into practical

development through policy influence and community engagement. Kamaara has consulted for the World Council of Churches, World Bank, U.S. Agency for International Development, United Nations Population Fund, and Templeton World Charity Foundation Inc., among others, and she has served on many international boards, such as the Church World Service, Social Science Research Council, and Medecins Sans Frontieres Ethics Review Board. She codirects the African Character Initiation Programme, a community-based and community participatory organization on mentorship of adolescents for health, well-being, and values, which has been recognized by the World Health Organization as among the Top 30 Africa Health Innovations.

KATTHYANA GENEVIEVE APARICIO REYES is a program officer in the Quality of Care Unit, Department of Integrated Health Services, World Health Organization (WHO). She has been working at WHO since 2006, where she has held various positions. In 2007, Aparicio Reyes joined the then Patient Safety Programme and played a major role in project management and evaluation of the Patient Safety Research Small Grants Program. Since 2013, she has been leading the Twinning Partnerships for Improvement initiative on partnerships between health institutions to improve the quality of health care, and has worked in other initiatives related to patient and family and community engagement. Aparicio Reyes provides technical support to Spanish-speaking countries as well as French-speaking countries in the aforementioned areas in quality and patient safety, multicultural project management, and partnerships between institutions. She has master's degrees from the University of Geneva in business administration and information systems, has completed training in project management at the Project Management Institute, and participated in Quality Improvement in Healthcare: the Case for Change from the Bath University.

SOLEDAD QUIROZ-VALENZUELA is deputy director of knowledge management at Universidad Central de Chile. She holds a PhD in biochemistry and molecular biology from Michigan State University and a master's in public policy and management from Carnegie Mellon University. Quiroz-Valenzuela is a lecturer,

researcher, and consultant specializing in science policy, advising, and diplomacy. She is currently vice-president for policy of the International Network for Governmental Science Advice and a member of the Expert Committee of the Evidence Hub for Latin America and the Caribbean.

ABHIMANYU KUMARASIVAM is a University of Cambridge–trained geneticist, educator, and science communicator. Before taking on his current role as provost of Sunway University, he was dean of the School of Medical and Life Sciences. His research in genetics involves elucidating components of the regulatory pathways that drive tumor recurrence and invasion, as well as dissecting Asian genetic variations that confer differences in disease risk and response to therapy. Kumarasivam has received multiple awards, including the National Cancer Council Malaysia Cancer Research Award, the Merdeka Award Grant, and the Gen.T List. In 2016, he became the first Asian to be named Best Science Communicator at the International FameLab Finals at the Cheltenham Science Festival in the United Kingdom. He was inaugural chair of the International Network for Government Science Advice Asia that supports the use of scientific evidence in informing policy at all levels of government. He also coinitiated and led Malaysia's first nationwide program on responsible conduct of research. Kumarasivam is currently co-chair of the Association of Southeast Asian Nations's Young Scientists Network. He sits on national and regional science and educational policy committees and has coauthored policy papers and reports.

SALLY K. STANSFIELD consults for and advises philanthropies, the pharmaceutical industry, IT firms, and global health initiatives. She was previously Deloitte Consulting's lead health systems strengthening specialist, with a focus on health information, communication, and technology; humanitarian emergencies; and global health governance. Stansfield served as executive secretary of the Health Metrics Network for the World Health Organization and as association director for the Bill and Melinda Gates Foundation's Global Health Initiatives. In addition, she has designed and managed programs for the U.S. Centers for Disease Control and Prevention, U.S. Agency for International Development, and Canada's International Development Research Centre. In these roles, she

investigated outbreaks, including of Ebola hemorrhagic fever, AIDS, and cholera. She has focused on building local capacity to set agendas, mobilize resources, and manage programs after cessation of international assistance. Stansfield has received several notable awards, including the Yale Tercentennial Medal, a Public Health Service Commendation, and a Fulbright Research Fellowship. She maintains an active medical licensure in the state of Washington, has board certification in internal medicine and emergency medicine, and is a fellow of the Uganda National Academy of Sciences. Stansfield holds a Doctor of Medicine from the University of Washington and a Bachelor of Science in psychological anthropology.

RASIGAN MAHARAJH is chief director of the Institute for Economic Research on Innovation at Tshwane University of Technology. He also serves as associate research fellow of the Tellus Institute, member of the Academy of Science of South Africa, and ministerial representative to the council of Rhodes University. His research critiques the contemporary political economy focusing on the global knowledge commons, and the dynamics of science, technology, and innovation. Maharajh held elected positions in various structures of the mass democratic movement and a national liberation movement during the struggle against apartheid. He was national coordinator of the Science and Technology Policy Transition Project for South Africa's first democratic government. Maharajh holds a Doctor of Philosophy from Lund University in Sweden and is an alumnus of the University of KwaZulu-Natal and the Harvard Business School. Since 2004, he contributed to more than 65 publications and presented his research in over 42 countries.

SHAILENDRA (SHAILEY) PRASAD is associate vice president for global and rural health at the University of Minnesota (UMN). There he is Carlson chair of global health and executive director of the Center for Global Health and Social Responsibility, professor and vice-chair of education in the Department of Family Medicine and Community Health, adjunct professor in the School of Public Health, and fellow at the Institute on the Environment. Prasad is also honorary visiting professor at the University of Cape Town, South Africa; at Ain Shams University in Cairo, Egypt; and at Udayana

University, Denpasar, Indonesia. He has been inducted into the UMN Academy of Excellence in the Scholarship of Education. Prasad is codirector of the UMN Rothenberger Leadership Academy and coleads the National Resource Center for Refugees, Immigrants and Migrants and the Northern Pacific Global Health Consortium. Prasad has worked in underserved areas, including rural areas, for 3 decades as a clinician, has conducted health services research, and has been engaged in education across disciplines. He has been part of the Rural Health Research Center at UMN, is on the steering committees of the Advocacy for Global Health Partnerships and the Global Engagement Network for Primary Health Care, and has been involved in academic department strengthening and mentorship training across various universities.

DAVID WEAKLIAM is consultant in public health medicine and director of the Global Health Programme in the Irish Health Service Executive. He is committed to addressing global inequities in health and has fulfilled multiple leadership roles internationally and in Ireland over the past 35 years. In his early career, Weakliam spent 12 years in Africa and Asia leading programs to improve health services and provide humanitarian assistance. From 2003 to 2007, he worked as health advisor for Irish Aid. Among other key roles, Weakliam served as chair of the ESTHER Alliance for Global Health Partnerships and was a board member of the Global Health Workforce Alliance. In his current role, he leads HSE partnerships for health service improvement with ministries of health in Mozambique, Ethiopia, Tanzania, Sudan, and Zambia and coordinates HSE humanitarian assistance to Ukraine, Sudan, and Gaza. Weakliam collaborates with the Irish Global Health Network on the ESTHER Ireland program, facilitating and supporting twinning partnerships with more than 20 countries in Africa and Asia. He is adjunct professor at University College Dublin and teaches widely on global health. And he directs several nongovernmental organizations, including Tearfund Ireland and Nepal Leprosy Trust Ireland.

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APPENDIX 2
Advocacy for Global Health Partnerships

Advocacy for Global Health Partnerships (AGHP) was established in 2017 as a coalition of global health stakeholders committed to promoting ethical standards in short-term global health engagements. Initially formed during a side event at the Consortium of Universities for Global Health conference, AGHP gradually transitioned from a loose network of concerned individuals into a more structured entity focused on advancing ethical practices in global health.

AGHP's first major initiative was the Brocher Declaration, a set of guiding ethical principles for short-term global health engagements (Prasad et al., 2022), which it intended to launch at a 2020 conference at the Brocher Foundation in Geneva, Switzerland. Although the event was postponed because of the COVID-19 pandemic, AGHP sustained its momentum through virtual global consultations, refining the Declaration, which was officially released later in 2020. Now endorsed by over 50 global organizations, the Declaration emphasizes key principles, such as mutual partnership, local empowerment, sustainability, and accountability.

In 2022, AGHP convened at the Brocher Foundation, bringing together global stakeholders to reassess its focus on short-term health engagements. During that meeting, AGHP expanded its mission to encompass broader global health partnerships beyond the short-term engagements outlined in the Brocher Declaration. As part of its commitment to challenging conventional models, AGHP established its secretariat at the Uganda National Academy of Sciences in Kampala. Since then, AGHP has continued to foster dialogue intended to strengthen global health partnerships.

In 2023, AGHP organized a side event at the headquarters of Gavi, the Vaccine Alliance, during the World Health Assembly. The event, which drew a standing-room-only crowd of key global health actors, underscored the ongoing need to address inequities in global health partnerships. As a result, AGHP commissioned a study through

UNAS to examine equity in global health collaborations, which was released in 2024. Also in 2024, AGHP launched a community of practice for organizations that have signed the Brocher Declaration, providing a space for shared learning and collaboration among those involved in global health partnerships.

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