



# Governance of global health research consortia: Sharing sovereignty and resources within Future Health Systems



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## ABSTRACT

Global health research partnerships are increasingly taking the form of consortia that conduct programs of research in low and middle-income countries (LMICs). An ethical framework has been developed that describes how the governance of consortia comprised of institutions from high-income countries and LMICs should be structured to promote health equity. It encompasses initial guidance for sharing sovereignty in consortia decision-making and sharing consortia resources. This paper describes a first effort to examine whether and how consortia can uphold that guidance. Case study research was undertaken with the Future Health Systems consortium, performs research to improve health service delivery for the poor in Bangladesh, China, India, and Uganda. Data were thematically analysed and revealed that proposed ethical requirements for sharing sovereignty and sharing resources are largely upheld by Future Health Systems. Facilitating factors included having a decentralised governance model, LMIC partners with good research capacity, and firm budgets. Higher labour costs in the US and UK and the funder's policy of allocating funds to consortia on a reimbursement basis prevented full alignment with guidance on sharing resources. The lessons described in this paper can assist other consortia to more systematically link their governance policy and practice to the promotion of health equity.

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## 1. Introduction

Global health research partnerships are increasingly taking the form of consortia that conduct programs of research and research capacity strengthening in low and middle-income countries (LMICs). These consortia are alliances of universities, research institutes, and other organisations such as commercial companies (Dockrell, 2010). Their research programs focus on product development (vaccines, drugs, diagnostics) for specific diseases; the delivery, safety, and cost-effectiveness of particular medical products for specific diseases; broader aspects of health systems (governance, financing, service delivery, human resources, information technology); or the social or structural determinants of particular diseases (Pratt and Hyder, 2016).

Such partnerships have increasingly been recognised as a

“powerful tool” to reduce global disparities in health and research capacity (CHRD, 1990; xvii; Ministerial Summit on Health Research, 2004; Global Ministerial Forum on Research for Health, 2008). By bringing together numerous partners that may span several sectors, consortia can leverage their aggregate intellect and resources to promote health equity. They are seen as an effective way to reduce duplication in research and develop research capacity, including by building closer South-South linkages (Dockrell, 2010).

*Governance* has been identified as a key mechanism for establishing and attaining health equity objectives (Ruger, 2011, 2012; Gostin, 2014). Governance of research consortia refers to their decision-making, encompassing the processes by which consortia make decisions about their goals, priorities, and allocation of resources; who makes such decisions; and the outputs of these processes. An account from political philosophy called *shared health governance* has been applied to derive initial ethical guidance on what features of governance are necessary for consortia (comprised of institutions from high-income countries and LMICs) to help reduce global health disparities (Pratt and Hyder, 2016). Shared health governance describes the type of governance needed to achieve global health justice and identifies five components as

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essential—advancing the goals of health justice, shared sovereignty, shared resources, shared responsibility, and mutual collective accountability (Ruger, 2011, 2012). The proposed ethical framework details what consortia should do to uphold each of the components of shared health governance (Pratt and Hyder, 2016). It was developed by bioethicists from the US. Feedback and input on its content have been sought from LMIC bioethicists and researchers.

According to the ethical framework, advancing health justice means three elements of consortia's research enterprise are key—their research priorities, capacity development strategies, and research uptake and translation strategies—because these elements can link their activities to the ends of justice<sup>1</sup> (Pratt and Hyder, 2016). Global health research consortia should ensure such elements are present and structured to promote the health of those with the poorest health globally. Sharing sovereignty calls for consortia to undertake priority-setting in an inclusive and deliberative manner led by LMIC partners. Sharing resources requires that consortia partners receive their fair share of consortia resources and allocate them to equity-oriented research, research capacity strengthening, and research translation activities. Mutual collective accountability entails agreement by consortia members on both the goals of their joint work and how it's to be judged (Pratt and Hyder, 2016). More detail on how consortia should uphold each component of shared health governance is provided in Fig. 1.

Although ethical guidance linking governance of transnational global health research consortia to the promotion of health equity is starting to be defined, practices capable of fulfilling it have yet to be described. Some work in bioethics has assessed whether global health research collaborations generate social value and advance health justice in LMICs (Pratt et al., 2014; Lairumbi et al., 2008), but these studies do not explicitly focus on collaborations' governance. As part of a first effort to explore whether and how consortia uphold shared health governance, case study research was undertaken with the Future Health Systems (FHS) consortium. FHS is a health systems research consortium funded by the UK's Department for International Development (DFID).

This paper examines the achievement of *shared sovereignty* and *shared resources* by FHS. These components of governance are especially challenging to realise in contexts of power disparities, so it is vital to document existing models of practice that promote their fulfilment. (FHS governance was also examined for furthering the ideals of health justice, but those findings are reported in a separate paper.) Data collected through in-depth interviews, observation at a 2014 FHS annual meeting, and examination of FHS documents were thematically analysed for alignment with proposed framework requirements for shared sovereignty and shared resources. Ultimately, the paper provides useful lessons for global health research consortia seeking to more systematically link their governance to their equity objectives. Insights from this case study also helped identify areas for revision and expansion of the ethical framework.

### 1.1. Proposed ethical guidance for sharing sovereignty and resources

Before assessing whether and how FHS achieved shared sovereignty and shared resources, it is necessary to first provide additional details on what doing so entails. Since shared sovereignty

requires *inclusive* and *deliberative* decision-making (Ruger, 2011), the ethical framework calls for consortia priority-setting processes to have both features. Inclusion encompasses not only who is invited to be present for priority-setting but also how they are involved in the process (Young, 2000). According to the framework, being inclusive means participants in priority-setting represent a wide spectrum of roles (senior researchers, junior researchers, research implementers) and demographics (genders, institutions) within a consortium. Similar numbers of participants with these roles and demographic characteristics should be achieved (Pratt and Hyder, 2016). Certain roles, e.g. senior researchers, and demographics, e.g. men, should not be disproportionately present relative to one another in order to ensure that they do not dominate priority-setting by force of numbers. It is highly desirable for priority-setting processes to be informed by research users and beneficiaries within consortia partners' countries, e.g. health policymakers, providers, and patients, especially those from disadvantaged groups (Anonymous). Additionally, measures should be in place to reduce the impact of power disparities on participants' opportunity to voice their ideas for priorities such as those between participants from different LMICs, researchers and implementers, and senior and junior researchers. This ensures that the views expressed in priority-setting processes are not solely those of more powerful actors.

Where countries are unable to ensure their population's health, global actors have an obligation of justice to take on a “supportive and facilitative role” to assist them to meet their responsibility and to build their capacity to do so on their own (Ruger, 2008, 433). The ethical framework, therefore, holds that when high-income country consortia members assume a role in priority-setting, it should *at most* consist of helping LMIC consortia members identify and decide upon research priorities that are relevant to their countries. It is then highly desirable that priority-setting processes involve an equivalent or greater mass of participants from LMICs and be structured to ensure that they have an equal (or greater) chance to share their proposed research priorities relative to participants from high-income countries (Pratt and Hyder, 2016).

According to the framework, being deliberative means participants are able to voice their ideas for consortia research priorities and justify them to the entire group, which should then have an opportunity for in-depth discussion, where the pros and cons of various proposals are debated. Proposals are refined and/or weeded out and participants coalesce around their preferred option(s). The final consensus should reflect the joint intentions of participants rather than the aggregation of unchanged individual preferences or simple agreement to the preferences of certain participants (Pratt and Hyder, 2016). Consensus as joint intentions means that consortia members have modified their positions in light of the positions of others during the deliberative process. Deliberation forges novel purposes/proposals that reflect the ideas of the group as a whole as opposed to the unchanged views of powerful participants within it (Richardson, 2002).

Sharing resources means that partners receive their fair share of resources and make efficient use of them to promote health equity (Ruger, 2011). As such, the framework proposes a greater proportion of high-income country partners' resources go to assisting with LMIC partners' research than to supporting their own research in LMICs. Here, LMIC partners' research is distinguished from high-income country partners' research based on who leads the project and whose interests are primarily served by its conduct. High-income country partners should generally not be allocated more total consortia resources than LMIC partners, though exceptions may exist (e.g. research involving highly expensive processes like genome sequencing that are largely performed in high-income countries). This principle applies to the overall consortia budget,

<sup>1</sup> Here, it is acknowledged that philosophers have conceptualised health justice in various ways and it continues to be a matter of debate (see Shue, 1996; Powers and Faden, 2006; Daniels, 2008; Ruger, 2012). In the ethical framework, health justice is defined as improving the health of those with the worst health globally, bringing them closer to the optimal level of health achieved worldwide.

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