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The strategic geographies of global health partnerships

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ABSTRACT

Global health partnerships have been hailed as a means of addressing the global health worker shortage, bringing forth health systems strengthening and, therefore, the universal health coverage aspirations of the Sustainable Development Goals. In contrast to other critical engagements with partnerships which have tended to focus on experiences and effects of these partnerships in situ; this paper draws on the example of the UK to explore how partnership working and development agendas have become entwined. Moreover, this entwinement has ensured that GHPs are far from the "global" endeavour that might be expected of global health and instead exhibit geographies that are far more representative of the geopolitics of overseas development assistance than biomedical need.

1. Introduction

In 2006, 57 countries were classified as having a serious health workforce shortage by virtue of failing to meet the World Health Organisation's (WHO) ‘critical threshold’ of the 23 health workers per 10,000 population needed to meet the health-related Millennium Development Goals (MDGs). Of these “Human Resources for Health (HRH) crisis countries”, 63% were in the WHO Africa Region (World Health Organisation, 2006a). Thus while African countries bore 24% of the global burden of disease in 2006, they had only 3% of the world's health workforce (World Health Organisation, 2006b). Given this, it is unsurprising that the “health workforce crisis” (*ibid*) came to be identified as one of the major factors undermining the Health Systems Strengthening (HSS) needed to achieve the health-related MDGs such as reducing child mortality, combatting AIDS, malaria and other diseases and providing access to safe, affordable medicine (Hafner and Shiffman, 2013). This urgency was further reinforced by a 2004 report by the Rockefeller Foundation's Joint Learning Initiative (Chen et al., 2004), the 2006 and 2008 *World Health Reports* and the World Health Assembly's (WHA) target of reducing the number of “crisis countries” by 25% by 2015. Yet, by 2013 and despite the energy mobilised by the 2008 Global Forum on Human Resources for Health in Kampala, a Global Health Workforce Alliance report noted that the number of “HRH crisis” countries had actually grown to 88 as population growth outpaced health worker recruitment (2013). As such and as Panter-Brick et al. note, it is clear that HSS ‘provides a crucial opportunity for global health action’ (2014, 4), even if its empirical substance and theoretical possibilities represent a persistent absence within the social scientific study of global health. This omission not only marks a limit of recent geographical engagements with global health (Brown and Moon, 2012; Herrick, 2014, 2016; Herrick and Reubi, 2017; Hinchliffe, 2015; Reubi et al., 2016; Taylor, 2016), but perhaps more importantly a missed opportunity to use GHPs as a vehicle through which to enhance the current conceptual language by which we think through the increasing entwinement of the global health and development domains (Murray, 2015; Rieder, 2016).

While HSS has – and continues to be - a widely-agreed prerequisite for the achievement of the health MDGs and now the SDGs, there has experienced consistent under-investment by the major global health funders and policy community (Hafner and Shiffman, 2013; Storeng, 2014). Instead funders have largely preferred to support ‘siloed’ vertical interventions to produce narrow MDG-driven results with the hope that, in so doing, ‘the [health] system will be strengthened more generally’ (Travis et al., 2004, 900). Yet ‘if health systems are lacking capabilities in key areas such as the health workforce, drug supply, health financing, and information systems, they may not be able to respond adequately to such opportunities… already weak systems may be further compromised by over-concentrating resources in specific programmes, leaving many other areas further under-resourced’ (*ibid*). Thus, competent health systems with an adequate workforce are essential to realise and sustain the benefits of what has been retrospectively termed the “golden era” of global health funding and investment (Kickbusch and Szabo, 2014; Morrison, 2012). This issue was picked up by Margaret Chan, WHO Director-General, in her assertion that single-disease initiatives and HSS ‘do not represent a set of either-or options. It is the opposite. They can and should be mutually reinforcing. We need both’ (Chan, 2009). It is thus notable that in contrast to the disease-specific MDGs; the SDGs directly note

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the centrality of HSS to achieving Universal Health Coverage (UHC) as well as avoiding the multiple, adverse consequences of "catastrophic" health expenses (Pablos-Mendez et al., 2016). As attention turns to the question of how best to deliver HSS (see Esser, 2009), I want to reflect on one increasingly important – but under-analysed - mechanism: The global health partnerships (GHPs) supported through the UK's Overseas Development Assistance (ODA) strategies. GHPs conjoin government, NGOs, civil society, universities, global health funders and the private sector. They aim to support national health strategies in LMICs, skills development provide technical assistance and deliver health worker training. Importantly, they also serve an essential geopolitical function in using health as a means by which to increase the UK's international influence, "soft power" as well as strengthening core skills and competencies in its own National Health Service (NHS).

In this paper, I will thus explore how these GHPs function as specific sites where global health and development meet and thus where particular geographies matter. These geographies are not representative of the spatial distribution of health "need" but rather of geopolitical and ODA exigencies. As such, here I will argue that critically reflecting on *where* GHPs are located is as important as dealing with the recent wave of calls to evaluate their efficacy (Lasker, 2016). Doing so will also mean pausing to consider the question of "who, then, global health is really for" (Horton, 2014). This exploration will proceed in three parts. First, I will set out the UK policy context in which GHPs for HSS have flourished. This is an important empirical contribution to the global health field in a context where the UK government's role has been remarkably under-explored by social scientists in this deeply US-centric field, despite the scale of UK ODA allocated to the sector. Second, I will explore how GHPs clearly demonstrate the increasingly blurred lines between global health and development and, therefore, the need to refuel current critical engagements with global health with a greater cognisance of the increasing interconnections between the two. In the third part, I will reflect on how the geographies of GHPs are far from benign and, also, far removed from the health needs they purport to address. Instead the geographies of GHPs are a reflection of a certain style of strategic geopolitical thinking angled towards delivering efficiency in ODA outcomes. As such, GHPs are not only potent geopolitical entities, but they also advance a particularly strategic uptake and deployment of geography itself. These geographies then become self-reinforcing as those countries prioritised as having the greatest "strategic advantage" by the UK's Department of International Development (DFID) then become the sites where GHPs are most likely to locate. In exploring this, I hope to open up a new arena of conceptual and empirical investigation not only to geographical engagements with global health, but also to the nexus where global health and development encounter each other.

2. The UK, global health partnerships and development

In 2006, Lord Crisp – past Chief Executive of the NHS - was commissioned by then-Prime Minister Tony Blair to write *Global Health Partnerships: The UK contribution to health in developing countries*. Emerging from discussions and promises made at the 2004 Commission for Africa, the 2005 G8 'Make Poverty History' Summit at Gleneagles and further cemented by the 2007 publication of the Chief Medical Officer's *Health is Global* strategy (Donaldson and Banatvala, 2007); the *Crisp Report* arguably set the stage for new era in global health governance in the UK. The G8 Summit highlighted that the global shortage of healthcare workers (especially in Africa) would need to be addressed to be able to realise the promise of basic healthcare for all (Smith and Henderson-Andrade, 2006). This issue was then taken up in the 2006 WHA Resolution (WHA59.23) on rapid scaling up of health workforce production, which was further underpinned by the rationale that the chronic shortage of health workers in LMICs was eroding the efficacy of the new global health financing mechanisms (i.e. the Global Fund, the GAVI Vaccine Alliance etc.). As a result, 'in many countries, there is simply insufficient human capacity to absorb, deploy and use efficiently the financing offered by global health initiatives' (World Health Organisation, 2006c). Furthermore, and as a series of recent anthropological accounts have shown, many of these initiatives create complex, parallel NGO/state/private healthcare economies (Crane, 2013; Marchal et al., 2009; Pfeiffer, 2013; Rieder, 2016; Taylor and Harper, 2014), often further perpetuating healthcare worker and skills shortages and resource allocation imbalances (Groenhout, 2012; Raghuram, 2009). For this reason, WHA Resolution 59.23 calls on all countries to implement sustained action to address the health worker crisis (World Health Organisation, 2006b, 5) with suggested strategies ranging from international investment in the domestic health workforce training pipeline, improving health education infrastructure, reducing medical school drop-out rates, enhancing the career development of Community Health Workers and producing a skills mix that better reflects biomedical and public health challenges. The WHO notes that this will require increased donor funding as well as a 'paradigm shift' away from disease-specific projects and interventions to investment in a more sustainable and holistic model able to 'properly address the technical and political challenges of health workforce development' (World Health Organisation, 2006b, 9). Amid this, GHPs have emerged as an important potential mechanism or 'lever of change' (Crisp, 2007) through which to effect and enact this paradigm shift.

The Crisp Report emerged from a belief that 'the UK and its professionals also have a great deal to learn and gain from people in developing countries, particularly in the context of international health challenges' (Blair in Crisp, 2007, iii). The report thus helped set the stage for a rapid proliferation of GHPs touted as the most opportune and cost-effective way to enact country-led development, addressing the global healthcare staffing crisis (see Bach, 2015; Kumar, 2007; List, 2009; Mackey and Liang, 2012) and servicing the proliferation of global health programmes and overseas medical electives at UK universities (Crane, 2011; Herrick and Reades, 2016). This not only gave the NHS a significant global health role – something later reinforced through the government's 2008 *Health is Global* strategy - but also echoed the broader policy momentum behind supporting health as a determinant and driver of economic development (Sachs, 2002; World Bank, 2007; Mitchell and Sparke, 2015; see also Mawdsley, 2015). Since the publication of the Crisp Report, the UK's commitment to GHPs has only grown. The Tropical Health Education Trust (THET) has managed DFID's health partnership scheme since 2006 and, to date, has supported 85 partnerships in 26 countries in Africa and Asia, which have involved 1000 NHS volunteers reaching 25,000 overseas health workers (THET, 2016).[1] The NHS commitment to partnerships and international volunteering is even formalised in its Constitution, with the 'business case' predicated on the belief that many global health challenges (e.g. tuberculosis) also affect the UK and may be better tackled through skills and insight gained by NHS staff while on placement in the global south. It is also bolstered by a belief that NHS staff undertaking international placements might forge the skills and experience needed to tackle the particular health needs of British citizens of overseas origin. NHS support for overseas placements for its staff within GHPs was also set out in the House of Commons International Development Committee's recent report *Strengthening Health Systems in Developing Countries* (2014) and

[1] THET partnerships fall into three categories: Multi-country partnerships; paired institutional partnerships and long-term volunteering. Examples include the University of Manchester's 'Lupina Africa Midwives Research Network' with midwifery schools in Kenya, Malawi, Zambia, Uganda, Zimbabwe and Tanzania (multi-country) and King's College London Sierra Leone Partnership's 'Education Strengthening Project' with Freetown's Connaught Hospital and the College of Medicine and Allied Health Sciences (paired institutional partnership) and VSO's maternal health in Malawi's long-term volunteering arrangements with the Kamuzu College of Nursing.

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