



Power, potential, and pitfalls in global health academic partnerships: review and reflections on an approach in Nepal

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ABSTRACT

Background: Global health academic partnerships are centered around a core tension: they often mirror or reproduce the very cross-national inequities they seek to alleviate. On the one hand, they risk worsening power dynamics that perpetuate health disparities; on the other, they form an essential response to the need for healthcare resources to reach marginalized populations across the globe.

Objectives: This study characterizes the broader landscape of global health academic partnerships, including challenges to developing ethical, equitable, and sustainable models. It then lays out guiding principles of the specific partnership approach, and considers how lessons learned might be applied in other resource-limited settings.

Methods: The experience of a partnership between the Ministry of Health in Nepal, the non-profit healthcare provider *Possible*, and the Health Equity Action and Leadership Initiative at the University of California, San Francisco School of Medicine was reviewed. The quality and effectiveness of the partnership was assessed using the Tropical Health and Education Trust Principles of Partnership framework.

Results: Various strategies can be taken by partnerships to better align the perspectives of patients and public sector providers with those of expatriate physicians. Actions can also be taken to bring greater equity to the wealth and power gaps inherent within global health academic partnerships.

Conclusions: This study provides recommendations gleaned from the analysis, with an aim towards both future refinement of the partnership and broader applications of its lessons and principles. It specifically highlights the importance of targeted engagements with academic medical centers and the need for efficient organizational work-flow practices. It considers how to both prioritize national and host institution goals, and meet the career development needs of global health clinicians.

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Background

Foundations in inequities

At their core, global health academic partnerships (GHAPs) involve complex and dynamic, typically

unequal power relationships between nations, people, and institutions [1,2]. GHAPs can help leverage resources such as funding, professional development opportunities, and clinical and research expertise from places of privilege and power in high-income

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countries (HICs) to improve healthcare delivery and systems design in low- and middle-income countries (LMICs) [3–9]. Similarly, there is increasing recognition of LMICs as drivers of innovation [10–13], and the personal and professional benefits that accrue to participants from HICs have been well documented [14–16].

Getting these partnerships ‘wrong’, however, can have grave consequences, such as iatrogenic harm, medicalization of poverty, the undermining and fragmentation of national healthcare systems through uncoordinated efforts, and the perpetuation of global north–global south exploitative relations [17–21]. Fostering impactful, ethical, and equitable engagements that strengthen national capacity and delivery systems in LMICs is challenging, precisely because these partnerships are often forged across staggering inequalities [1,22].

A growing body of literature, broad in scope and disciplinary focus, examines the assemblages of actors from rich and poor countries that make up GHAPs [23]: these include universities, international/non-governmental organizations, external donor partners, philanthropic foundations, research groups, and government bodies such as Ministries of Health. Many articles reveal the ethical dilemmas and potential unintended consequences – as well as the blurred definitional and operational boundaries – of short-term medical missions [24,25], global health electives [26,27], and medical volunteer trips [28–32]. Others seek to delineate qualities of effective global health partnerships [33], create principles and codes of ethical engagement [19,34–39] that may guide the creation of ethically sound and successful partnerships, or facilitate the improvement of existing ones [40].

Partnership is an increasingly amorphous term in global health and itself in need of scrutiny. The term ‘partnership’ can be misused as an almost ideological construct or panacea. We prefer to use the term as a generative and dynamic concept [41] that holds the potential to further projects for equity and social justice.

To hone in on the specific dynamics involved, we describe a partnership between the Ministry of Health (MoH) in Nepal, the non-profit healthcare provider *Possible*, and the Health Equity Action and Leadership Initiative (HEAL) at the University of California, San Francisco School of Medicine. The partnership was formed with the explicit purposes of: (1) strengthening public sector healthcare systems and national capacity through education and mentorship of LMIC-based healthcare workers, (2) serving patients in marginalized communities, (3) avoiding the pitfalls of ‘medical voluntourism’ and other forms of intermittent or inconsistent care [42], and (4) creating mutually beneficial opportunities for professional development and personal growth for both visiting and local team members.

We begin by briefly discussing the broader landscape of GHAPs, summarizing some of the key challenges to developing ethical, equitable, and sustainable models from the perspectives of host institutions and global health clinicians (GHCs). We then lay out guiding principles that animate the Nepal partnership’s approach to GHAPs, and discuss its experience over the last 2 years. We assess the quality and effectiveness of the partnership utilizing the Tropical Health and Education Trust (THET) Principles of Partnership framework [39], and discuss strengths and limitations of the partnership. We conclude with considering how lessons learned might be applied to create effective and equitable GHAPs in other resource-limited settings.

Framing the landscape of global health academic partnerships: opportunities and challenges

While there remains no standard definition of ‘global health’ [18], efforts have been made to move towards a common definition [43]. Key features include the incorporation of research and practice with a priority of achieving health equity worldwide, and a recognition of the need for an inter-disciplinary, multi-directional approach that reaches beyond the health sciences to address these inequalities [43]. The contemporary state of our world remains characterized both by a deep interconnectedness and by marked inequalities in health and wellbeing within and between countries. The world’s interconnectedness and inequality is a necessary departure point to discuss the challenges at the center of many GHAPs.

Academic partnerships can help to address global inequalities by promoting research and advocacy to support progressive policy agendas [44], to advance medical education [9], and to retain healthcare workers in rural and other settings of economic marginalization [14,45]. Healthcare delivery organizations in LMICs can benefit from financial and human resources from which they are typically excluded. Both sending and host institutions use partnerships as a tool for recruitment and retention [15,45,46]. Healthcare workers in host institutions benefit from knowledge and skills transfer, as well as the support of being connected to an academic environment, which can attenuate some of the difficulties of working in isolation [3]. GHCs benefit from opportunities not readily available at their home site, as well as a chance to align their work with their ideals [47].

Despite these potential benefits, it is challenging for host institutions to meaningfully engage academic clinicians to leverage their expertise in an effective yet empowering way. Most global health work is part-time and intermittent by nature, due to clinical, research, and administrative responsibilities at academic centers. In a survey of US post-residency

clinicians with global health work experience, 73% reported spending < 10% of professional time on global health in the prior year [48]. As such, GHCs have the potential to contribute to ‘ephemeral healthcare’, where fleeting forms of service delivery are not integrated within longitudinal systems [42]. The objectives of GHCs and their funding sources do not often align with the greatest needs of local communities [49,50], and the sustainability of GHAPs is challenging when relying on GHCs for their time commitment and efforts to fund themselves.

Existing global power structures place academic institutions, and especially physicians, at the top of power hierarchies. Due to the often irregular and brief nature of these engagements, partnerships featuring these GHCs have the potential to undermine the autonomy and agency of local staff and leadership [20,21]. The one-sided nature of travel and opportunities in most academic partnerships risk further exacerbating inequalities among global healthcare workers [27]. Advocating for reciprocity can partially mediate this concern [18,51], although bi-directional exchange requires additional resources, and, in many cases, travel opportunities are further complicated by inequalities in global visa systems. Without an orientation to local culture, language, and the plural healthcare practices of communities, it is difficult for GHCs to provide value [20,52]. An additional burden is often placed on local hosts to transport, house, feed, and translate for GHCs, thereby potentially sidelining their own areas of responsibility in favor of the interests and projects of visiting clinicians [53].

From the perspective of GHCs, it is challenging to build a productive career in global health. Global health priorities are typically not aligned with current pathways for compensation and promotion [48,54]. In one survey of hospitalists with ongoing global health work, 78% reported receiving no institutional funding, and experienced an overall lack of mentorship, support, or recognition for their global health work [55]. Family life also leads to conflicting priorities, and is an important consideration for academic clinicians [48]. Without a viable, professional career pathway, GHCs compelled by global health often fall into volunteer endeavors. As such, the medical voluntourism model tends to be the default approach to global health work, despite a growing awareness of the accompanying problems of a lack of durability, effectiveness, and accountability [42,56]. Below we discuss our efforts to create a partnership attendant to the perils of this model.

Review

Organizational context

The MoH directly provides essential public health and primary healthcare services throughout all 75

districts in Nepal. In a healthcare economy that has increasingly become dominated by fee-for-service for-profit private providers [57], the MoH has started to look towards public–private partnerships (PPPs) to strengthen the public sector. *Possible* is a non-profit healthcare provider that has pioneered an approach with the MoH, through which the government provides facilities, staff, supplies, and co-financing, and *Possible* assumes management authority and is held accountable for direct healthcare delivery within government infrastructure. The partnership is deeply sensitive to the contentious nature of PPPs in the arena of global healthcare delivery [58,59], and the shared goal is to both meet public sector delivery gaps in rural areas and provide a platform for public sector innovation. *Possible* targets an annual per capita price point of \$US25, based upon the current levels of public sector financing in Nepal. Through the partnership, *Possible* has treated over 500,000 patients since clinical services began in 2008, and now averages over 130,000 treated per year.

Possible employs over 280 staff in Nepal, all of whom are Nepali citizens. A sister US-based non-profit provides technical and financial support. No expatriates are involved in clinical care in *Possible*’s model, since expatriate clinicians would never affordably be financed by the Nepali government. In addition to meeting both service delivery and innovation gaps, *Possible* aims to strengthen public sector human resource capacity. Most mid-level providers (e.g. health assistants, community medical assistants, staff nurses, auxiliary nurse midwives, pharmacists, and laboratory staff) are from the local areas, and if they leave *Possible*, tend to transition via the *lok sevā* – the Nepali public service commission. Physicians tend to be recruited from urban areas and, thus, are more transitory. After working with *Possible* for a period of 1–2 years, some seek residency training in the US, a phenomenon on the rise with recent batches of Nepali medical graduates [60]. Others transition to national post-graduate programs or directly into the public service.

HEAL is a global health equity fellowship based at the University of California, San Francisco with the goal of creating, scaling, and sustaining a pipeline of HIC- and LMIC-based healthcare professionals to care and advocate for poor and marginalized communities in the US and abroad. Essential to HEAL’s mission is to promote two-way dialogue and exchange, and to make more equitable partnerships that directly confront typical power dynamics between HIC and LMIC institutions. As part of its initiative, HEAL currently places rotating fellows in 2-year engagements, divided between foreign placements (Haiti, India, Liberia, Malawi, Mali, Mexico, and Nepal) and marginalized communities in the US. Rotating fellows are paired with site fellows from their respective communities.

Over the last 3 years, together the MoH, *Possible*, and HEAL initiated an exchange involving expatriate GHCs and Nepali staff. The program had its roots in long-standing relationships between several of the co-authors from HEAL and from *Possible* (in particular co-authors PL and DM did residency together). HEAL was also looking for new partners to iterate on the notion of partnership. *Possible's* leadership, particularly its Nepali physician staff, ultimately decided that working with HEAL would help to bring global perspectives and knowledge to their clinical care. Vital to *Possible's* own view of HEAL's value proposition was that Nepali staff members would receive international opportunities. The MoH had long supported expatriate clinician-educators from *Possible* to augment national capacity, contingent on the mandate that they would not be displacing Nepali jobs and followed all legal frameworks. All of us involved in the conceptualization and implementation of the partnership brought extensive experiences in global health and had seen many of the pitfalls and power dynamics at play. Indeed, core to the founding and evolution of this partnership were our own prior mistakes. Below we explore the guiding principles and lessons learnt over the years of our collective work.

Recruitment and management systems

The partnership currently brings on three GHCs, known as HEAL fellows, every year for 2-year commitments. HEAL fellows are screened and selected based on their experience and qualifications as they relate to organizational priorities, and a commitment to strengthening healthcare delivery systems through clinical education and mentorship. Additionally, HEAL fellow candidates are assessed by their motivation to contribute to global health equity, respect for local priorities, alignment with *Possible's* culture code, and commitment to cultural humility. Supplemental Table 1 includes the rubric HEAL uses to assess prospective GHCs and assess the right fit of the applicant for their international placement, and a rubric used by *Possible* to assess a prospective GHC's fit with the MoH and *Possible's* PPP model. HEAL fellows spend roughly 50% of their professional time working with *Possible*, and 50% working clinically in a marginalized area in the US. They are early career clinicians, typically 1–2 years out of residency or fellowship training.

Possible seeks to integrate GHCs fully into organizational systems and structures, and especially its mission of public sector strengthening. GHCs receive a structured 'onboarding' to the organization's culture code, goals, management systems, and project management tools. GHCs are also introduced to all organizational departments to facilitate interdisciplinary connections

and break down 'siloed' working environments. GHCs are encouraged to learn deeply about Nepal, including socio-demographic and health trends, historical and contemporary patterns of structural violence, national and regional political economies, agricultural and changing dietary patterns, and plural systems of healing. Cultural and language resources are provided, with recognition that mastering the Nepali language for a 2-year fellowship is an unreasonable expectation.

As part of the integration process, GHCs are assigned a direct manager and a faculty coach. Direct managers are the Nepali medical director at the GHC's site who conduct weekly structured meetings, develop quarterly work plans, and conduct biannual performance evaluations akin to full-time employees. They aim to ensure GHC expertise is leveraged in an effective and empowering way, in which full-time staff view these engagements as a resource rather than a burden. Faculty coaches have a funded engagement with *Possible*, and an academic appointment at a US university. They meet monthly to support GHCs, with a goal of ensuring accountability, and that the strategic mission of the organization is being prioritized. Roles of the coach include support for research and writing, and attention to career development needs. These are unique given that expectations for promotion and departmental funding may be outside the expertise of the manager. Included in the supplementary materials is an organizational protocol detailing the division of labor between manager and faculty coach, which helps ensure these roles leverage each other effectively (Supplemental Table 2). An example of a structured meeting template and a set of GHC areas of responsibilities are provided in Supplemental Files 1 and 2, respectively.

Scope of work by global health clinicians

GHCs contribute largely to providing clinical education and mentorship, developing training materials and protocols, and coaching around quality improvement. Notably, as part of the Nepal PPP, GHCs do not participate in direct service delivery, but rather serve in an advisory role, as their primary areas of responsibility involve building the clinical and technical expertise of Nepali providers. As signatories to the Non-Governmental Organization Code of Conduct for Health Systems Strengthening [61,62], *Possible* seeks to adhere to hiring practices that strengthen national healthcare systems, including 'employing available national expertise, particularly where unemployment of highly qualified nationals abounds'. A critical strategy of the PPP is that non-Nepali providers add value by building national capacity, and not by providing care themselves. Indeed, by leveraging the MoH and *Possible's* existing healthcare delivery

PPP, we have avoided the challenges in coordinating multiple, disjointed expatriate clinicians that so often happen in the healthcare sector [37,42].

GHCs additionally support implementation research efforts through *Possible's* research arm, the Healthcare Systems Design Group [63], training around digital systems, and co-authorship on academic publications. Here we view the contribution of co-writing manuscripts not solely from the lens of GHC promotion. Rather, we consider disseminating findings central to the principle of beneficence in implementation research, as well as important for furthering equitable opportunities for LMIC authorship [64].

Reciprocity in professional development opportunities

A central consideration – and perhaps the biggest challenge – for GHAPs is seeking equity and reciprocity. While one might expect a ‘get one, take one’ approach [27], this is typically not the case. Indeed, there are great asymmetries in the distribution of opportunity and benefit involved in GHAPs. The flow of opportunity, mobility, as well as social and professional capital, trends largely to participants and institutions from wealthier countries. As part of the partnership, *Possible* nominates qualified Nepali staff to receive intensive global health training in the US, structured mentorship through HEAL, and the

opportunity for fully sponsored enrollment into master’s degree programs in the US and UK as site fellows. HEAL also facilitates site exchanges at other international partner sites by including both site and rotating fellows of the Nepal partnership to exchange knowledge with their counterparts around the world. Fellowships are not solely available to doctors, and HEAL has provided fellowships to pharmacists, social workers, administrators, and government officials. The current ratio of US rotating fellows to Nepali site fellows is 3:2. The ratio of rotating to site fellows across all HEAL partner sites, which includes domestic US sites serving marginalized communities, is 1:1.

Reciprocity also comes in the form of financing, acknowledging the extreme disparities involved in HIC academic medical centers and LMIC organizations. To ensure sustainability, most funding comes from the US academic institutions affiliated with HEAL. Some organizational costs for onboarding, travel, lodging, and administrative support are born by *Possible*, which budgets US\$8,000 per Fellow per year.

Framework and measures for impact

The effectiveness of GHAPs is notoriously difficult to quantify [2], as are the potential unintended consequences and costs of getting these partnerships wrong. In Table 1, we organize the key components of this partnership model within the THET Principles

Table 1. Nepal partnership model within the THET principles of partnership framework.

<p>Strategic Health partnerships have a shared vision, have long-term aims and measurable plans for achieving them, and work within a jointly-agreed framework of priorities and direction.</p>	<ul style="list-style-type: none"> • Formal engagements maintained with academic medical centers. • Targeted recruitment of academic clinicians and post-graduate fellows.
<p>Harmonized & Aligned Health partnerships’ work is consistent with local and national plans, and complements the activities of other development partners.</p>	<ul style="list-style-type: none"> • Measurable objectives reviewed on a quarterly basis. • Managers ensure strategic mission of organization is prioritized. • Structured orientation to organization’s goals, management systems, and communication tools.
<p>Effective & Sustainable Health partnerships operate in a way that delivers high-quality projects that meet targets and achieve long-term results.</p>	<ul style="list-style-type: none"> • Managers collaborate to align goals with organizational objectives. • Partnership objectives designed to influence national priorities by integrating closely with the MoH. • Partnership duration of 2 years is targeted. • Diverse funding sources including academic institutions and research grants. • Internal metrics of effectiveness applied, along with site evaluation tools designed for GHCs.
<p>Respectful & Reciprocal Health partnerships listen to one another and plan, implement, and learn together.</p>	<ul style="list-style-type: none"> • Bidirectional exchange with career development opportunities for Nepali staff. • Faculty coaches address the career development needs of academic partners.
<p>Organized & Accountable Health partnerships are well-structured, well-managed, efficient, and have clear and transparent decision-making processes.</p>	<ul style="list-style-type: none"> • Formal memorandum of understanding addresses management structure, lines of accountability, and individual responsibilities. • Structured workflows facilitate orientation, travel, lodging, visa, and medical licensing.
<p>Responsible Health partnerships activities are conducted with integrity and cultivate trust in their interactions with stakeholders.</p>	<ul style="list-style-type: none"> • GHCs participate in organizational performance evaluations. • Strong organizational culture code reinforced with academic partners. • Managers ensure GHC’s presence is empowering rather than undermining for full-time staff and leadership.
<p>Flexible, Resourceful, & Innovative Health partnerships proactively adapt and respond to altered circumstances and embrace change.</p>	<ul style="list-style-type: none"> • GHCs are introduced to all organizational departments to facilitate interdisciplinary connections. • Details of each partnership negotiated individually to allow for flexibility.
<p>Committed to Joint Learning Health partnerships’ stakeholders monitor, evaluate, and reflect on their activities and results, articulating lessons learned, and sharing knowledge with others.</p>	<ul style="list-style-type: none"> • Opportunities for reflection and feedback are structured into meetings with managers and faculty coaches. • Results of partnership shared organizationally via a newfeed. • Results shared publicly through media, academic conferences, and open-access, peer-reviewed publications.

of Partnership framework [39]. THET describes eight principles for partnerships to be effective: they should be (1) strategic; (2) harmonized and aligned; (3) effective and sustainable; (4) respectful and reciprocal; (5) organized and accountable; (6) responsible; (7) flexible, resourceful, and innovative; and (8) committed to joint learning. We find this framework useful for assessing the quality of engagements at several levels, including personal, organizational, healthcare systems, and population.

We also qualitatively measure partnership success by asking the Nepali clinical leadership team at *Possible* the following question: Am I (and/or my team) being supported in my role by GHC partners? As the quality improvement mantra states, ‘you cannot improve what you do not measure’, and this maxim applies here. Yet, thus far, we have struggled to measure and track this precisely as it applies to our Nepal partnership. We have developed an instrument to evaluate the success and satisfaction of GHCs with the Nepal partnership, as shown in Supplemental File 3. We will continue efforts to quantitatively and qualitatively measure the success of partnerships and search for novel metrics to reflect their value, in order to facilitate ongoing iterations and improvements. Ideally, we would identify a way to institutionalize an iteration on this THET Principles of Partnership framework for internal improvement and partnership-building; outside of this paper, however, we have yet to do so.

Limitations of the partnership model

There are several limitations to the model. The investment of fully integrating academic partners into the organization is time- and labor-intensive. The cost is lowered in *Possible*'s organizational structure by strong existing and templated workflow practices, as well as a clear delineation of roles. Thus, other organizations may find this process more burdensome.

While we aim to build equity into our partnership, the inequities that exist between team members from HICs and LMICs are largely indelible. We would like to better bring in other voices throughout the organization, particularly among those who do not speak English and are not among the leadership team. This will be an important next step in refining our partnership. One strategy would be to conduct focus group discussions and key informant interviews with Nepali providers to better understand strengths and challenges of the partnership.

While the partnership works to address career development needs of GHCs, the barriers are not mitigated entirely, in large part because GHC career paths are often difficult to define. HEAL is considering a larger study of the long-term career outcomes of GHCs within both this partnership and other sites.

That longitudinal analysis will bring some evidence to bear on the questions of the value proposition to the GHCs.

Most importantly, global healthcare delivery demands tools and perspectives from multiple disciplines. As one example, the emergent field of implementation research, also called implementation science – broadly defined as the application of rigorous mixed methods to the adaptation, testing, and scaling of innovative, effective interventions with the goal of closing the ‘know-do gap’ and shaping broader policy environments – brings together the gamut of disciplines concerned with improving health and healthcare systems: from medicine and the allied health sciences, to demography, operations research, political science, and medical anthropology [65–70]. While we focus here on clinician partnerships, we have not yet figured out how to deliver responsibly on other forms of engagement, and this remains a weakness because of the immense importance of other disciplinary approaches towards understanding and addressing plural approaches to health and healing.

Our Nepal partnership experiences also may have limited generalizability, as this is one partnership in a specific context with a unique set of partners. Challenges inherent to measuring the success of academic partnerships remain significant here. We apply the THET Principles of Partnership framework as a heuristic to partially mitigate this concern, though it does not address efforts to compare the effectiveness of different partnership models. We focus on several aspects of the partnership model we feel important, although it is likely there are numerous intangible aspects which remain unmentioned in this paper.

Conclusions

It is challenging for host institutions to leverage GHCs in effective and equitable ways, and similarly challenging to identify viable pathways for clinicians to do this work responsibly. Here we provide a descriptive account of one approach, highlighting key structural and relational components that have helped to mitigate the challenges of GHAPs. We acknowledge that the concept of true partnership is elusive and is more accurately realized as part of a continuous process rather than an achieved state.

Insights from our approach include: the importance of prioritizing targeted engagements with academic medical centers; the need for efficient organizational work-flow practices to minimize integration cost; and the ideal of prioritizing national and host institution goals, while simultaneously addressing the career development needs of GHCs. The complementary roles of managers and faculty coaches deserves repeating as a key aspect of this model. The direct manager internal to

the organization addresses GHC accountability to and alignment with organizational priorities, aimed at supporting rather than undermining local providers and leadership capacity. GHC relationships with faculty coaches address networking, research, manuscripts, funding sources, and career development. Managers and coaches are, thus, able to leverage each other's skills and perspectives to bring value to the work of *Possible* and the GHC. Building an equitable partnership will take time, flexibility, and iteration. If we are to disrupt traditional partnership models where the locus of power, resources, and opportunities trends asymmetrically towards HICs and GHCs, we must pay special attention to deep and persistent inequities.

While the approach we take here is unique to our organizations and setting, this descriptive account will ideally help other organizations create new partnerships and refine existing ones that promote strengthening national capacity and public sector healthcare systems.

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Author contributions

Developed initial partnership concept: DC, BA, SS, PL, D Schwarz, R Schwarz, S Maru, SH, DM. Contributed to refining partnership: all authors. Researched the THET Principles of Partnership framework and compiled other authors' answers to how our partnership fits into the framework: DC, S Mehanni. Evaluated partnership: DC, S Mehanni, BA, LW, IN, R Sherchen, BG, SS, PL, D Schwarz, R Schwarz, BD, SKD, S Maru, BD, DM. Contributed to writing the manuscript: DC, S Mehanni, DM. Reviewed and approved the manuscript: all authors. ICMJE criteria for authorship met: all authors.

Disclosure statement

DC, IN, RSherchan, BG, BD, SKD, RM, PT, AR, IB, SPK, and SH are employed by and SMehanni, BA, LW, DSchwarz, RSchwarz, SMaru, GD, and DM work in partnership with a nonprofit healthcare company (*Possible*) that delivers free healthcare in rural Nepal using funds from the Government of Nepal and other public, philanthropic, and private foundation sources. DC is a faculty member at a public university (University of Washington), and DC and SH are employed

part-time there. SMehanni, BA, LW, SS, PL, and GD are employed at a public university (University of California, San Francisco) and BA, SS, and PL are faculty members there. SMehanni, BA, LW, IN, RSherchan, BG, SS, PL, and GD work in partnership with a bidirectional fellowship program (HEAL Initiative) that is affiliated with a public university (University of California, San Francisco) that receives funding from public, philanthropic, and private foundation sources. BA is a co-founder of a nonprofit healthcare organization (Shared Minds) that provides training and support for mental health professionals in low-resource settings using philanthropic funding. SMehanni works in partnership with a public medical center on the border of a Native American reservation (Gallup Indian Medical Center) that is managed using public sector funding through the Indian Health Services. LW works in partnership with a medical center (Gallup Indian Medical Center) that receives revenue through fee-for-service medical transactions and private sector grants. KBK, DRSingh, and MA are employed by the Government of Nepal. DSchwarz, RSchwarz, and DM are employed at and SMaru is an academic fellow at an academic medical center (Brigham and Women's Hospital) that receives public sector research funding, as well as revenue through private sector fee-for-service medical transactions and private foundation grants. DSchwarz and DM are employed at an academic medical center (Boston Children's Hospital) that receives public sector research funding, as well as revenue through private sector fee-for-service medical transactions and private foundation grants. RSchwarz is employed at an academic medical center (Massachusetts General Hospital) that receives public sector research funding, as well as revenue through private sector fee-for-service medical transactions and private foundation grants. DM and RSchwarz are faculty members at a private University (Harvard Medical School). SM is employed at an academic medical center (Boston Medical Center) that receives public sector research funding, as well as revenue through private sector fee-for-service medical transactions and private foundation grants. SM is a faculty member at a private university (Boston University School of Medicine). SPK is a faculty member at a private university (Eastern University). GD works in partnership with a medical center (Tséhootsooi Medical Center) that is managed using public sector funding through the Indian Health Services and receives revenue through fee-for-service medical transactions. DM is a non-voting member on *Possible's* board of directors, but receives no compensation. All authors have read and understood Global Health Action's policy on declaration of interests, and declare that we have no competing financial interests. The authors do, however, believe strongly that healthcare is a public good, not a private commodity.

Ethics and consent

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Paper context

The benefits of global health academic partnerships include promotion of research, advocacy, and medical education. However, such partnerships may undermine local priorities and perpetuate exploitative relationships. Guidelines have been developed to facilitate the creation of effective, equitable partnerships. This paper explores the practicalities of a concrete partnership to demonstrate how guiding principles can be translated into tangible models. Moving forward, the inclusion of additional perspectives, and development of robust partnership measurement tools would add value.

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