Understanding global health and development partnerships: Perspectives from African and global health system professionals

Abstract

Partnership is a key idea in current debates about global health and development assistance, yet little is known about what partnership means to those who are responsible for operationalising it or how it is experienced in practice. This is particularly the case in the context of African health systems. This paper explores how health professionals working in global health hubs and the health systems of South Africa, Tanzania and Zambia understand and experience partnership. Drawing on semi-structured interviews with 101 professionals based in each country, Washington DC and Geneva between October 2012 and June 2013, the paper makes four key arguments. First, partnership has a legitimating function in global health policy processes for international development institutions, government agencies and civil society organisations alike. Second, the practice of partnership generates idiosyncratic and complicated relationships that health professionals have to manage and navigate, often informally. Third, partnership is shaped by historical legacies, critical events, and independent consultants. Fourth, despite being an accepted part of global health policy, there is little shared understanding of what good partnership is meant to include or resemble in practice. Knowing more about the specific socio-cultural and political dynamics of partnership in different health system contexts is critical to equip health professionals with the skills to build the informal relations that are critical for effective partnership engagement.

Key words: Africa, partnerships, health policy, global health and development assistance, health systems, health professionals

Introduction

Partnership is a pervasive idea in policy debates about global health and international development assistance (Youde, 2014; Rushton & Williams, 2011: Buse & Tanaka, 2011). It was central to the Millennium Development Goals (8: Develop a Global Partnership for Development), is core to the Paris Declaration and Accra Agenda for Action (OECD, 2014), and is a stated goal of international funders, development agencies, and national governments. The idea of partnership is also central to debates about the post-2015 global health and development agenda. Not only is partnership an integral component of the Sustainable Development Goals (SDGs) (UN, 2015), but there is also recognition that a renewed sense of partnership holds the key to their successful implementation (UNGA, 2014).

Yet questions remain as to: what does partnership actually mean to those who are responsible for operationalising it as a policy idea within health systems? How is partnership currently experienced? And what might this tell us about the continued use of the idea in global health and development assistance policy? Despite widespread official commitment to partnership, these questions have received limited attention in existing global health and development literature. As a result, partnership continues to remain 'one of the most over-used and under-scrutinized words in the development lexicon' (Harrison, 2002:589). While there is a rich and varied literature on partnership within selected western health system contexts, such as the UK (see Hunter and Perkins, 2014), there has been limited direct engagement with the policy of partnership in relation to global health where the context for partnering is quite different (Moran & Stevenson, 2014); not least because of the significance of aid transfers to poorer countries and the associated relationships that can emerge in such settings.

Existing global health and development literature has tended to approach partnership in one of two ways: 1) from a *pragmatic-instrumental* perspective, and 2) from a more *critical* position. The first treats partnership as an inherently progressive policy intention, which should be implemented and, moreover, be implementable in practice. Here, partnership is understood to be about realising equality, trust and/or mutuality in health and development relationships and ensuring that recipients of aid in poorer countries, especially national governments, are empowered as agents of their own health systems and wider development (Conway *et al.*, 2006; Brinkerhoff, 2002; Youde, 2014).

The need to create more equal and synergistic relationships has been a recurrent issue in the history of global health and development, with persistent charges of ineffectiveness and neo-colonialism directed towards external funding agencies (Baaz, 2005; Abrahamsen, 2004). These criticisms became acute during the 1980s and early 1990s due to conditions attached to aid provided by agencies such as the World Bank, in an attempt to encourage governments of poorer countries to enact structural reforms to health systems and the economy. Such conditionality was widely criticised for being coercive and undermining national ownership of policy processes (Harman, 2010; Loewenson, 1993; Bhutta, 2001). The idea of partnership became increasingly popular in health and development circles as a response to these criticisms. It was not only promoted as a way to return power, influence and leadership to national actors within low income settings – transforming a donor-driven health and development relationship into one of equality – but also as a way of ensuring that complex health and development challenges could be met and resources used effectively (Barnes and Brown, 2011). Pragmatic-instrumental literature tends to take this understanding of partnership as given, and focuses on the extent to which these policy intentions have been, or can in future be, achieved in different health system and development settings. Suggestions for improving performance have tended however to focus on global institutional design or

74 governance of national hosting arrangements (Buse and Tanaka, 2011; Kraak and Story,
75 2010; Buse and Harmer, 2007), with only limited attention to the politics of partnership
76 during implementation (Kapilashrami and McPake, 2013).

77 The second, *critical* perspective sees partnership differently. Here, it tends to be
78 understood as a political slogan, misrepresentation or form of empty rhetoric that conceals
79 other motives and thus largely rebrands 'old-style' paternalistic intentions of international
80 health and development agencies (Baaz, 2005; Crawford, 2003; Fowler, 2002; Impey and
81 Overton, 2014). According to this perspective, international partners remain in a position of
82 disproportionate control within partnership, at least in part because they have found it hard
83 (or never intended) to create more equal, nationally-led health and development relationships
84 (Baaz, 2005; Impey and Overton, 2014).

85 Reports of health funding conditionality, issues of coordination within health systems,
86 and country level challenges associated with pendulum swings in global health (Schrecker,
87 2014; Williamson, 2008; Hill et. al., 2011) suggest it would be easy to dismiss partnership in
88 this way. Such reports infer that there remains little local room for manoeuvre, and thus that
89 partnership has not been translated into real health and development practices. As several
90 researchers have shown however, local practices are often more contested, complicated and
91 'dirtier' (Kapilashrami and McPake, 2013; Mosse, 2005; Harrison, 2010) than both the
92 *pragmatic-instrumental* and *critical* literature has suggested. These researchers highlight
93 how policy processes increasingly operate from global to local scales (i.e. within and between
94 global health hubs and national health systems) and involve a range of partners – in
95 government, funding agencies and civil society. These groups have diverse agendas and
96 interpenetrated relationships, and interpret, appropriate and encounter policies differently
97 (Gould, 2005; Harman, 2010; Kapilashrami and McPake, 2013; Mallarangeng and Van Tuijl,
98 2004; Mosse, 2005; Sridhar and Craig, 2011).

As such, ‘partnerships’ are likely to be translated and experienced in different ways by professionals whose responsibility it is to operationalise the policy from global through to national levels. There has been limited space for the views of these professionals in current global health and development literature on the topic (Sridhar and Craig, 2011), and particularly in the context of African health systems. Thus, we know little about how key actors understand partnership within African health systems; whether those who are located at different levels of governance see partnership as a relation of equality or (as suggested above) as empty rhetoric; or how partnerships work from their perspective in practice (Aveling and Martin, 2013). This is a significant gap given the pervasiveness of partnership on global health and development assistance agendas and the immense scope and scale of the challenges that remain within health systems (Sridhar and Craig, 2011). The implementation of future global policies relating to partnership will inevitably be shaped by understandings and past experiences (Mosse, 2005). It is therefore important that such perspectives are brought forward in order to inform ongoing policy debates about partnership, and to provide relevant information for professionals who work in partnership settings.

The aim of this paper is to address this gap by reporting findings from in-depth interviews conducted with professionals working within the global health hubs of Washington DC and Geneva, and within the health systems of South Africa, Zambia and Tanzania. By drawing on both global and national perspectives, the paper seeks to present a multi-sited and systemic understanding of partnership, which not only takes account of the ‘big picture’ of global health and international development (e.g. wider political and economic factors, institutional structures), but also the relational complexities of everyday practice (Sridhar and Craig 2011; Aveling and Martin, 2013). The paper outlines the research process and moves on to discuss professional perspectives on the meaning of partnership and how it has been operationalised in practice. The paper shows that partnership has a

legitimating function within global health policy processes, yet there is little common understanding of how good partnership is practiced or experienced. Partnership is critically shaped by historical legacies, focusing events, and independent consultants in South Africa, Tanzania and Zambia, and generates idiosyncratic relationships that health professionals need the skills to manage and navigate, often informally.

Methods

The findings reported here come from a wider project looking at global health assistance and diplomacy. One aspect of the work involved an exploration of the idea and practice of partnership. A qualitative methodology was employed involving multiple methods. A detailed policy and literature analysis was conducted in order to: identify formal processes, events and institutions associated with health policy and partnership working in South Africa, Zambia and Tanzania; and identify key actors involved in policy conception and delivery within the global health hubs of Washington DC and Geneva and each African country (Barnes et. al., 2015).

Washington DC and Geneva were selected as research locations given that prominent global health institutions are located there, thus affording the opportunity to speak to key global level professionals. South Africa, Tanzania and Zambia were selected to provide comparative insights. In terms of comparison, all have stated commitment to partnership at country-level and have similar national structures for partnership working (see discussion below). In terms of difference, the gross domestic product and national reliance on external funding for health was significantly different, thus offering the potential to understand how wider economic conditions shape partnership experiences.

Having conducted the initial policy and literature analysis, schematic maps were produced of the formal spaces that exist for partnership within health policy at different

levels. These informed field research subsequently undertaken at global and national levels: facilitating the purposeful identification of key informants for interview and meetings to observe. Potential informants not engaged in formal partnership processes were also identified (e.g. civil society organisations (CSOs), academics) in order to construct a balanced understanding of partnership.

In total, 101 professionals participated in semi-structured interviews between October 2012 and June 2013 in each country and in Washington DC and Geneva. Interviews were conducted with 21 professionals based in the headquarters of the World Bank, Global Fund to Fight AIDS Tuberculosis and Malaria (Global Fund), WHO, UNAIDS, USAID and Inter-American Development Bank in one-on-one or group settings. At national level, 80 semi-structured interviews were conducted in South Africa (n=24), Tanzania (n=32) and Zambia (n=24) with professionals working in: government health and finance ministries, UN agencies, World Bank, other funding agencies, CSOs and processes associated with the Global Fund (e.g. Country Coordinating Mechanisms (CCMs) and principal recipient programmes). Professionals working in the East Central and Southern Africa Health Community (ECSA HC) and Southern African Development Community (SADC) were also interviewed. In Tanzania, the Annual Health Sector Review (October 2012), Fifth P4P Advisory Committee (October 2012) and Joint Annual HIV/AIDS Technical Review (November 2012) were observed.

Qualitative data was analysed iteratively *via* thematic analysis: sorting, labelling, summarising using pre-agreed themes (e.g. meaning of partnership, challenges, strategies) whilst also allowing for the identification of emergent ones, detecting patterns and subsequently developing a detailed understanding of partnership. Exemplary quotations have been selected to illustrate themes emerging from the data in the sections below.

Results and Discussion

Professional perspectives on the meaning of partnership

Of the 101 global health and development professionals interviewed, all were familiar with and comfortable in using the term partnership. This, to some extent, reflects the pervasiveness of the idea in global policy debates, and demonstrates that it has been broadly accepted into the cognitive architecture of global and national health policy actors (Green, 2007; Mosse, 2005). However, interviews revealed that there were clear differences of opinion as to what partnership means in relation to health and development. The discussion below summarises the main ways in which partnership was understood and how different understandings are significant because they manifest in competing views about which, and how, different stakeholders should be involved in health governance.

Competing understandings

A number of professionals across the case study locations discussed partnership in terms of equal collaboration, mutuality, and comparative advantage: as being about bringing together stakeholders who have differing skills, backgrounds or knowledge to meet a common challenge or achieve common goals (e.g. delivery of quality health services or efficient resource use). Here, a synergistic relationship was envisioned between partners, in which collaboration would bring more than each partner could achieve on their own:

> The partnership, that means we have to work together, to support each other, collaborate in doing things to make things more quality together. (16TZOct2012).

> I think key, for me, is partnership is also looking at what strengths each other have. Also, it helps in terms of using the resources effectively… if you go into partnership you find synergies there. (11ZMJun2013).

In many respects, this perspective reflected the *pragmatic-instrumental* approach to partnership highlighted above. As such, those who expressed this view indicated that there should be scope for different actors to be involved within the health system (a 'multi-sectoral' approach): not only government and international agencies, but also other country-level stakeholders across civil society and the private sector, with roles and responsibilities to be determined by relative skills and knowledge (Brinkerhoff, 2002; Conway *et al.*, 2006). As one UN official in Zambia suggested:

> Partnership is sitting, I see a round table not a table with someone at the head... where everybody is given a chance to say what they know best, no matter who they are… at the end you are all able to speak towards what needs to be done… (13ZMJun2013).

In contrast, some professionals working in CSOs in Zambia and Tanzania indicated partnership was about more overtly political and participatory ideals: voice, advocacy and securing broad engagement in health systems processes. Here, partnering was understood as being about challenging the way health policy was developed and, moreover, about challenging the perceived dominance of health and other government ministries. There was also a tendency to discuss partners in terms of power and influence. As one Zambian CSO professional indicated, 'I think there is power in coming together' (19ZMJun2013).

In Washington DC, and for World Bank professionals in particular, partnership also seemed to be understood in an explicitly political way. Partnership was discussed as being

about health system governance and, moreover, about governance improvement and reform. World Bank professionals emphasised the important role of 'civil society', noting that CSO partnerships for health and development had been 'Jim Wolfensohn's legacy' at the Bank (9WSSep2012). As one official emphasised: 'There is an understanding on our part that this is the way we do business' (5WSSep2012).

Finally, and in contrast to the perspectives set out above, other professionals working in Zambia and South Africa spoke of partnership in a much narrower, contractual way: as being about financial exchange and driven by global funding (10ZMDec2012, 22ZMNov2012, 24ZMNov2012; 20ZMDec2012; 5SAFeb2013; 1SAMar2013). Partners tended to be discussed in terms of their funding roles – who gives and who receives – often with some mention of differentiation between, for example, multilateral and bilateral funders and the different ways in which government or CSOs could receive funding (e.g. trust funds, sub-granting, budget support). For these professionals, partnership resonated more closely with 'old-styles' of aid funding (see above): in which health and development processes are shaped and driven by donor-recipient aid relations (Crawford, 2003).

The above discussion clearly demonstrates that professionals who are responsible for operationalising partnership 'buy-in' to the idea, yet have different and, indeed, competing understandings of what it means. To some extent, this is unsurprising given the lack of conceptual clarity surrounding the term (Barnes and Brown, 2011). Instead, the meaning is 'worked out' by professionals as partnerships are operationalised (Mosse, 2005). Significantly, and as the discussion below demonstrates, key actors must also 'work out' and promulgate their own roles within partnership, so as to legitimise their involvement in health at global and/or local levels. As we will see, such legitimisation is important because it allows individuals and organisations to access funding and/or enhance their status, thus

allowing them to continue operating in what is an increasingly competitive global health and development industry.

'Working out' roles in a competitive and changing global health context

A number of professionals working in CSOs across South Africa, Tanzania and Zambia were keen to emphasise that their organisation was 'different' to others. Their organisation's unique history of engagement in health, accumulated experience, or broad networked structure were all highlighted as important in terms of either gaining access or being of ongoing value to local health partnerships. Presenting themselves as 'different' seemed important because it allowed professionals to stake a legitimate claim in partnership processes. Being seen as a legitimate partner is important for CSOs in Tanzania, South Africa and Zambia because of the material benefits that partnership can bring, both for individuals and organisations. Being a partner to Global Fund CCMs can, for example, facilitate access to global funding. Similarly, being seen as, and subsequently participating as, a legitimate partner in a range of other partnership spaces (e.g. sector-wide reviews, consultations, workshops) also helps secure access to funding, given the informal links that can be made with senior (often influential) officials from international agencies or government bodies, or through the per diems that may be attached to these meetings (Barnes et al. 2015). Per diems, in particular, are often an important form of salary support for CSO workers (and also government officials) contributing to household budgeting and financial planning (Vian et al., 2012), and can thus bring real material benefits to health professionals and their families. At the same time, given the competitive funding environment that exists for CSOs in South Africa, Zambia and Tanzania, being accepted as a legitimate partner has an important effect on organisational sustainability. As one Zambian CSO professional put it: 'Getting money is life or death for organisations' (22ZMNov2012).

A number of professionals working in international agencies also indicated the importance of 'working out' and promulgating their organisation's role in global and local partnerships. UN officials based in South Africa, Zambia and Tanzania indicated that their agencies had a unique role in health, given that they focused on relationship-building and not money. UNAIDS, for example, was identified as being 'different' for brokering relationships between government, global institutions and other country-level partners, and for providing technical skills where needed:

> I think part of UNAIDS' role is we invest a lot of time in building contacts… I certainly invest a lot of my time in meeting people informally and just chatting about things (14ZMDec2012)

World Bank professionals in Washington DC also emphasised that the Bank's role was about more than money and emphasised this had become a necessity given recent shifts in the global aid architecture and type of support that African states (in particular) were looking for. Bank officials explained, for example, that while 'the Canadians… have a huge focus on maternal and child health' and 'the Americans have a lot of stake in malaria and HIV/AIDS', the Bank offered a broader 'package' of technical and financial support (11WSSep2012, 8WSSep2012): bringing key partners (particularly CSOs) around the table in dialogue, convening analysis and promoting evidence use. For the Bank, 'working out' these partnership roles was critical given apparent concern about a decline in the Bank's 'health standing' (9WSSep2012). This has, at least in part, been a function of the increased supply of other global health funding in recent years, which means Bank support has become less attractive (Harman, 2015). African states, in particular, have also increasingly sought support for income-generating infrastructure projects (such as rail or power), rather than health

systems funding because they provide opportunities to recoup financing to pay off development loans. In consequence, there was not only a need for the Bank to reemphasise its role as a global health partner, but to also re-stake its claim as a 'Knowledge Bank' for health systems:

> ...the need for direct Bank financing may actually decline however it does not necessarily mean the need for Bank partnership in other ways as a co-convenor of high impact fora, an institution that can ask some questions and help bring experiences from elsewhere to the table, that does not necessarily have to decline… (1WSSep2012).

Significantly, this repositioning of the Bank's global partnership role was seen as a challenge because of the way in which the Bank's legitimacy as a partner is judged. Academics, health professionals, governments and other agencies expect the Bank to contribute to health systems strengthening (e.g. Hill et al., 2013) and Bank staff suggested that the Bank's total financial contribution was often assessed, as opposed to its role in providing technical support (i.e. knowledge) for health systems:

> …the trouble is the outside world doesn't measure the composition of our technical assistance as closely as the composition of our financial assistance, so they see these things such as the health clinic, the health programme… it's a side show (8WSSep2012).

These insights reveal the complexity and political messiness of partnership. This complexity stems, at least in part, from the fact that there is no shared meaning for

partnership and, relatedly, from the fact that there are competing views about which and how different stakeholders should be involved in health governance. Partnership clearly has a legitimating function for many actors, which is seldom discussed in existing literature or policy debate on the topic. This is a critical omission because the legitimisation process is politically mobilising: it ties the interests of different actors together (Mosse, 2005) precisely because they all derive their legitimacy, at global and/or national levels from partnership policy. In other words, the identities and status of different actors are tied up with partnership. While this facilitates collaboration between professionals who have competing views about health governance, there is a constant risk of conflict (Lewis and Mosse, 2006); particularly in instances where noted differences in views about health governance threaten the legitimacy of particular actors to engage in partnership.

At a broader level, although the instrumentalist intent of partnership may be to promote collaboration or understanding, in practice many government and civil society actors in aid-recipient states, to a greater or lesser extent, feel pressure to engage in the 'right kind' of partnership so as to ensure they are seen as reliable and legitimate partners. Engaging as the 'right kind' of partner (i.e. amenable to donor and development partners) is a key way of maintaining access to decision-making about where funding goes, and/or their position as aid recipients. This is in many ways an extension of the 'post-conditionality' practices identified by Harrison (2004), whereby African states present reformist measures as a means to attract continued development aid.

Understanding more about these legitimating functions of partnership is important if we are to improve how partnerships are conceived and implemented in the future. Indeed, this is particularly important because, as the next section demonstrates, the dissonance in views about health governance (noted above) clearly manifest in the way that partnerships for health are experienced, resulting in: 1) a series of challenges for those who are responsible for

operationalising the idea; and 2) particular strategies that different actors seek to pursue in the course of partnership working.

Professional perspectives about how partnership works

Commitment and positive progress

Most of the professionals interviewed indicated that there was some level of commitment, openness and willingness on the part of those they regularly interacted with, at either global or national level, to work in a collaborative partnership. Many examples of progress to broaden participation in partnerships for health were highlighted. In particular, improvements in the nature of the interaction between different groups within South Africa, Zambia and Tanzania were highlighted, alongside efforts to achieve more balanced forms of communication. It was reported, for example, that the dynamic between government bodies and agencies such as the World Bank, USAID and DfID had generally improved in recent years, with the former now more able to shape the content of the health agenda without being overtly steered by outside agencies (who had their own preferences). One step forward here was the formalisation of principles such as 'country ownership' in global policy statements, which provided a common reference point for regulating the actions of aid donors:

> …the scenario has definitely changed from a donor-driven agenda to a country-driven agenda… the reason is that I think at the global level the policies that have been developed have deliberately gone that way… when it is written black and white like that they have to adhere to what they have said... (2ZMNov2012)

The existence of institutional frameworks for partnership, which had had time to 'mature', as one UN official in Zambia put it (11ZMJun2013), was also widely agreed to have been a step forward. Technical working groups, annual reviews, subcommittees and formal networks all exist within the three case study countries. These report and feedback to each other and provide formal spaces for government ministers, civil servants, CSOs, development partners, and the private sector to engage. These spaces have all, to some extent, been set up in response to global statements about partnership relations and (at least in principle) are intended to work in a coordinated way with other country-level partnerships, such as Global Fund CCMs (Sridhar and Craig, 2011; Barnes et al., 2015; Sundewall, 2009).

Professionals in each country highlighted the importance of time in building long-term confidence, trust and productive dialogue in not only these formal institutional spaces, but also in informal interactions. Indeed, confidence and trust were widely reported as being critical for creating an environment in which such dialogue could occur. A point emphasised in wider studies within health systems (Farmer, 2011). Also reported as important, and a positive development in South Africa in particular, was strong leadership in supporting the process of trust-building, forging informal links and brokering relations where these were previously strained. Changes to leadership of the South African CCM (SANAC) from 2012 were, for example, reported to have improved communication, resulting in greater efforts to listen to experts, CSOs, international organizations and provinces. Leaders within the South African government were also reportedly more willing to engage those previously 'outside of the inner circle of friends and trusted organizations' (9SAFeb2013, 10SAMar2013).

The findings set out above suggest that a common, practical basis for health partnerships exists in South Africa, Tanzania and Zambia, and thus that there are existing institutional foundations for partnership to work in the SDG era. There was certainly a general consensus that partnership is an appropriate policy norm and that there have been

steps to make partnership a reality. The pragmatic-instrumental literature described above emphasises the importance of the institutional foundations for partnership (e.g. Buse and Harmer, 2007) and the findings presented here validate this point. Indeed, of particular significance for current debates about partnership and the SDGs is the recognition that global statements, whilst somewhat divorced from 'the day-to-day', have potential to shape the framework for relationship-building, and have positively influenced the ability of African actors to exert control within interactions. This suggests that the incorporation of partnership as goal 17 in the SDGs, and in future SDG statements, might be an important way to continue support for country-level control within health systems (UN, 2015).

This is not enough however, given the critical importance of informal relationships within health partnerships. This is particularly pertinent when thinking about how specific actors enter into partnership agreements. Formal participation structures dictate that government agencies and key donors will participate. However who gets to participate from CSOs is based much more on informal links derived, for example, from revolving door employment, umbrella groups, and familial and friendship networks. Moreover, leadership was highlighted as being key at country-level; not just in formal partnership spaces but in supporting informal trust-building via brokering relations between partners, in and through interactions which are relatively 'hidden' from view (Lewis and Mosse, 2006; Farmer, 2011; Harman and Rushton, 2013). While the topic of leadership within health systems is under-researched, recent studies have highlighted the multi-polar networks and complex 'organizational ecology' within which leaders are embedded, which support such informal brokerage processes (Chigudu et al., 2014).

'Normal' challenges yet differing agency and control

Importantly, while the above-mentioned positive steps forward in partnership were highlighted, a range of challenges were also discussed. To some extent, these were understood as 'normal' given that it was recognised that all working relationships brought issues that needed to be overcome. As a UN official in Tanzania commented: 'With any partnerships there's always some challenges right? (12TZOct2012). The challenges discussed however, reveal important insights about the agency and level of control that African actors can exert, which, as discussed below, are constrained by factors including: the historical legacy of past interaction, critical events, the way consultants engage in partnership processes, and a lack of clear systems for mutual accountability.

As indicated above, professionals across South Africa, Zambia and Tanzania all indicated that confidence and trust were critical in supporting productive dialogue between partners. However, in all countries, these were seen to 'ebb and flow' as a result of factors including changes in external funder priorities and national political leadership. In Zambia, the Patriotic Front coming in to power in 2011 brought considerable change to ministerial structures and in the appointment of senior personnel, which a number of professionals (outside government) indicated had stifled dialogue. Critical events, such as the discovery of the misappropriation of funds by Ministry of Health staff in 2009 ('the troubles') were also reported to have fractured trust between partners. The situation was similar in Tanzania, with corruption, European political change, and the global financial crisis all reshaping the context for collaboration (28TZOct2012). These wider political developments, both nationally and globally, clearly had an important structuring effect on everyday partnership (Sridhar and Craig, 2011); shaping both the material basis for partnership (i.e. reduction in aid transfers) and complicating the relational basis too (i.e. fracturing trust).

Significantly, professionals working across South Africa, Zambia and Tanzania all raised concerns about the way consultants (international accountants, private companies,

national research teams) were engaged in partnership processes. While consultants were never directly referred to as 'partners', there was concern about their level of influence given that they were often intimately involved in developing partnership documentation, strategic policy documents, and/or assessing the extent to which partnership indicators or targets had been met. Preparation of the National AIDS Strategic Framework in Tanzania had, for example, been 'outsourced' to consultants and consultants were contracted in all three countries to prepare national submissions to the Global Fund and appraise progress. This type of outsourcing is increasingly common across African health systems (and indeed occurs in policy processes outside health) (Sridhar and Craig, 2011; Gould, 2005). The concern here was that consultants often end up doing so much work that they are extremely instrumental in final policy decisions (see also Sridhar and Craig, 2011). Although the work of consultants can capture elements of partnership when exercised in concert with government and other stakeholders, it risks becoming a way for local partners to abdicate responsibility, or for consultants to promote particular preferences (such as those of the external agencies they are often funded by) where there is weak internal organisation.

Professionals were especially critical of the actions of some partners and, in particular, those of the Global Fund. Across all countries, the Global Fund was widely regarded as a 'challenging' partner, given the organisation's inflexible, bureaucratic and constantly changing processes for accessing and managing funding. These issues were generally seen as being restrictive, creating internal pressure to change existing governance systems to meet demands (sometimes reasonably or unreasonably) and as a threat to local coordination. These issues are not unique to South Africa, Tanzania and Zambia, with similar problems reported in, for example, Cambodia (Aveling and Martin, 2013) and India (Kapilashrami and McPake, 2013).

There was some reluctance to raise these issues directly with the Fund in Tanzania and Zambia for fear of jeopardising financial flows. In contrast, critical views were particularly strong in South Africa wherein the Fund was commonly referred to as a 'failing' partner by private sector, UN and government officials alike. One government official went so far as to suggest the Fund was engaged in 'economic colonization' (6SAFeb2013). These critical views were, in part, an expression of local frustration about the particular way in which Global Fund CCMs have been a tool for political and health brinkmanship in South Africa (wherein provinces like Western Cape could outscore national performance on health thus making their claims for national autonomy more salient) (Barnes et al. 2015). They also signify however, a greater ability of South African professionals to 'push-back' against Global Fund partnership requirements than those in Zambia and Tanzania, who felt unable to hold the Fund to account:

> … since we are the ones that want the money, they always have the upper hand... most of the time because we are the recipient NGO, we end up saying okay, fine, I agree with all of the above and you sign (18TZOct 2012).

In terms of explaining this, South Africa is less economically dependent on external financing than both Tanzania and Zambia, and this, at least in part, seems to affect the freedom afforded to professionals working in the South African health system to express their views and thus exert control within partnerships (Barnes et. al., 2015). In other words, the extent of economic dependency affords them greater 'negotiating capital' and political leverage in decision-making (Gould, 2005; Whitfield, 2010).

Significantly, underpinning accountability problems is the uncertain legality and consequences of what happens when one partner does not meet expectations. Partnership

relations are often formalised in local forms (e.g. Memorandums of Understandings (MoUs), donor-recipient financial agreements), which are intended as institutional mechanisms for partners to hold each other to account (Sundewall, 2009). There are, however, problems with the way in which these mutual accountability mechanisms are developed and adjudicated in practice. Not only do partnership MoUs have limited legal standing (and are therefore of limited value when disagreements occur, as was the case with the Zambian 'troubles' of 2009), but there is also confusion as to which law arbitration clauses in financial agreements pertain. Interviewees were either uncertain about this or assumed that contracts fell under South African/Tanzanian/Zambian law. The reality, however, is that this depends on the country and funder:

> …arbitration clauses start by saying that if there is a difference we will try and amicably resolve… If it fails we will try the arbitration law of the implementing country… And the arbitration act says you appoint an arbitrator who is mutually acceptable to both parties…There are times when the donor has insisted that the applicable law… will be like the US but we have refused… (2ZMNov2012).

The idea that the default law is not that of the country in which a partnership is implemented suggests a legal asymmetry to partner relations that has not been fully explored in existing research. Moreover, it suggests an asymmetry in which African stakeholders could have limited effective control over funding partners. There are certainly strategic efforts to more robustly hold external agencies to account in each country. The Tanzanian government is, for example, seeking to formally assess donors annually (28TZOct2012). There are questions however, as to how this will play out in practice, and the strategies that might be employed to navigate the accountability process.

It will be important to generate more evidence about these accountability issues in order to construct more balanced partnerships in future.

A final issue relates to the way in which formal partnership structures operate in practice. While formal spaces for interaction were generally regarded by most African and global health professionals as a step forward in terms of supporting collaborative relations, there was widespread concern these were not working optimally. A range of difficulties were discussed, which not only related to technical issues of management, but also to the micro-politics of interaction.

Professionals in Zambia and Tanzania (from CSOs, government and external agencies alike) expressed concern about the volume of 'cumbersome' meetings which took up time, indicating that debate tended to be 'process-orientated… rather than substantive dialogue' (28TZOct2012). This not only resulted in few clear decisions, but also limited informal discussion and wider 'blue-skies' thinking about how to address health system issues:

> … we could spend all day everyday in a committee or meeting… people aggregate the partnership responsibility to that structure. So they think that we don't need to discuss things over a coffee or a lunch because that has been taken care of… it doesn't necessarily occur to them that you can do something differently (14ZMDec2012)

Others, including professionals in South Africa, questioned whether the right technical health groups were represented and expressed frustration about the shifting and sometimes competing orientations of external agencies, which undermined how discussion and decision-making progressed; a view supported by some professionals who were themselves working in external agencies:

> …there are real fundamental problems with the way development assistance is working here… Policy dialogue with government and donors, they don't spend a lot of time talking to each other… we as donors haven't got our act together, let alone engage with government. (12TZOct2012)

Crucially, the lack of productive dialogue in formal institutional spaces also partly appears to be a result of active political strategies employed by government health officials, and thus reflects the way these professionals exert their agency within partnership. Government silences within formal meetings, in which donors are left to talk, can, for example, be an attempt to obfuscate decisions and thus evade the control of outside agencies (7TZOct2012). Similarly, it can be a strategic practice for senior officials to send junior staff to meetings, who do not have delegated authority to debate issues, in order to continue government activity 'behind closed doors' away from donor view. While reflective of African agency in partnership relations, these practices can be the source of local frustration, consume time and creative energy (Eyben, 2010), and result in paralysis in moving forward with decisions that require partner input:

> … there is some delegating taking place here and you have junior people, that is the general story, not being able to take decisions… its felt a bit offensive on DP (development partner) side. (28TZOct2012).

These examples illustrate that government stakeholders are able to exert some level of control over the pace and timing of partnership relations; deploying strategies which seek to deflect the oversight of funding agencies (Bergamaschi, 2009; Gould, 2005, Mosse, 2005). Yet, as the above discussion on the role of consultants and accountability relations illustrates, they do so from an uneven footing and operate within a complex set of everyday partnership

practices which we still know relatively little about. Of particular concern is the lack of dialogue and 'blue skies' thinking noted above, which is arguably contributing to deliberative closure (Eyben, 2010), in Tanzania and Zambia in particular. This process effectively 'produces ignorance' (Mosse, 2005) about health systems issues; closing down opportunities for professionals to learn from, challenge and address them.

Conclusion

This paper has explored what partnership means to those responsible for operationalising it as a policy idea within health systems and to understand how partnership is experienced within existing practice. It is clear that partnership as a global policy making framework has emerged as an accepted norm by professionals working in the global health hubs of Washington DC and Geneva, and in the health systems of South Africa, Zambia and Tanzania. The practice of partnership reveals idiosyncratic and political properties that professionals working in global health must regularly manage. Being involved in partnership has an important legitimating function for health policy stakeholders and where this legitimacy is brought into question it risks setting up relations of competition and conflict (Mosse, 2005). Partnership relations are further challenged by the historical legacy of past interaction and critical events, and are skewed by the way local or international consultants are engaged in the process and by a lack of clear systems for mutual accountability (Sridhar and Craig, 2011).

Global efforts to institutionalise the principle of partnership have been one means of enhancing the ability of African government officials, in particular, to more fully control health agendas and there is evidence to suggest that practical strategies are being employed within partnership relations in order to consolidate national ownership. Consolidating these within the SDG process will be a further way to balance the uneven global health and

development playing field within African health systems. To focus on institutional mechanisms however, is not enough (Kapilashrami and McPake, 2013; Aveling and Martin, 2013). The key to better partnership rests with better understanding the more political elements of partnership practices, the way strategies are deployed to appropriate partnership processes and evade control (Whitfield, 2010; Bergamaschi, 2009), and the way closer relationships of trust can be brokered (Lewis and Mosse, 2006; Mosse, 2005). Such knowledge is important because it provides crucial information about the socio-cultural constraints and political dynamics of partnership, upon which health professionals can evolve their own practices and build the informal relations that are critical for effective engagement. Given that leadership and informal brokering are important here, it is crucial that health professionals have skills in these areas. This suggests a need to ensure that professional training covers topics such as politics, negotiation and diplomacy, so that those responsible for operationalising partnership are able to forge and negotiate effective informal relationships.

Finally, the global health and development assistance community generally expect policy to be informed by evidence. This appears not to have been applied to policy relating to partnership. This is a critical omission given that partnership continues to direct global health and development policy processes (UN, 2015). The findings here illustrate the importance of generating qualitative evidence about what partnership means in different contextual settings to those who practice it, so as to more fully understand: whether and how partnership can advance and/or delimit other health policy objectives; and appraise what avenues exist to reform both the institutional *and* relational aspects of partnerships in ways that increase prospects of success. One of the values of the idea of partnership is that it is a policy norm that brings disparate groups together around a shared concept. Ongoing perceived failures in

the practice of partnership risk delegitimising this norm and could ultimately result in weakened forms of global health cooperation.

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