A US-Kenya Partnership: a model North-South 'unequal friendship' in health research where balanced priority setting remains but a mirage[1]

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Brief description of case study context

Findings from a research study that I led back in 2017 reveal that a Global North - South collaborative partnership is a form of Aristotelian 'friendship among unequal parties' (Nderitu and Kamaara, 2020). A friendship of unequal parties consists of a superior partner and an inferior partner. The superiority and inferiority of partners is based on the expected contributions and benefits of each partner: the superior party is expected to provide tangible benefits and in turn expects 'immaterial' benefits, while the inferior party is the recipient of the material gains and gives 'honor'[2] in return (Irwin, 1999).

The IU-Kenya Partnership, built solely to improve health of the Kenyan public through the interrelated tripartite missions of education, research, and clinical service (Tierney *et al*., 2013; McIntosh & Kamaara, 2016; Mercer, T., Gardner, A., Andama, B. *et al*., 2018) between Moi University and Moi Teaching and Referral Hospital (both in Kenya) on one hand, and a consortium of health research institutions in North America led by Indiana University on the other (Einterz *et al*., 1995), was the case under study.

The IU-Kenya Partnership has always strived for equity, if not equality, since its initiation more than three decades ago though this remains to be one of the big challenges (Tierney et al., 2013). "A fundamental principle of this partnership is that academic institution and health system strengthening are built on the integrity of mutually beneficial and mutually respectful individual counterpart relationships between North Americans and Kenyans at all levels (Mercer, T., Gardner, A., Andama, B. *et al*., 2018)". For example, in one of the most successful programmes of the Partnership and in fact one the largest university health partnerships in the world[3], and which has become synonymous with this Partnership known as the Academic Model Providing Access to Healthcare (AMPATH) Research Network, the overall directorship, research working groups, research cores, and specific research projects are each co-led by a partner from both Kenya and North America.

It was revealed by the findings of the study that institutions and partners from Kenya get enormous benefits including: healthcare infrastructure and institutions leading to significant improved healthcare for the community, capacity strengthening for Kenyan partners by training, mentorship, and research funding, increased research activities leading to higher university rankings, and research ethics capacity strengthening (Nderitu and Kamaara, 2020). This is compared to the immaterial benefits akin to Aristotle's 'honor' that the North American partners and institutions received, e.g., pride and satisfaction for altruism by working with communities and institutions in a developing country (Nderitu and Kamaara, 2020). Though, in addition, they gained knowledge of tropical diseases, competence in

[1] Discussion in this paper is based in my PhD thesis developed from field data that began in 2017: David Nderitu (2019). *An Analysis of Aristotelian Analogy of Friendship Among Unequal Parties: The Case of IU-Kenya Partnership*. Unpublished Thesis, Moi University, Department of Philosophy, Religion and Theology.

[2] According to Aristotle honour is the intangible reward of virtue and beneficence

[3] https://international.iupui.edu/global-learning/partnerships/archive/kenya/

clinical care due to the hands-on experience in Kenya (McIntosh & Kamaara, 2016) academic career progression and higher university profiles (McIntosh & Kamaara, 2016; Nderitu and Kamaara, 2020) mainly due to the ease of getting research grants for collaborating with Kenyan partners and also for creating publication opportunities essential for such career growth.

Ethical issues in the IU-Kenya Partnership

Even though Kenya evidently receives the greatest overall tangible benefit in the IU-Kenya Partnership and despite great desire for equality, there are aspects that imply that the partnership is lopsided. The inequities are implied in some responses from the research and the discussions by the collaborators regarding their experiences, and also from the description of the collaborators' work in the Partnership. Implicitly this is evident through imbalance in agenda setting, decision making, roles of partners and also assumption of positions in various programs and projects of the Partnership (Tierney et al., 2013; Nderitu and Kamaara, 2020) and remuneration of partners (Tierney et al., 2013). For example, in all these aspects the North American partners were shown to take the upper hand vis-a-vis the Kenyan partners. This has implications on the notion of priority setting in research for global north-global south partnerships. In a way, there was a perception from some Kenyan partners implying that since the global north provides funds then it needs to have a bigger stake on the decision of how the funds are utilized in terms of the areas of research, the type of projects and the management of the funds. Furthermore, the fact that the North American partners have the best training in certain specialized areas of healthcare and in research methodology compared to the Kenyan partners (Tierney et al., 2013; Nderitu and Kamaara, 2020) some parties from both sides of the partnership were of the opinion that the North American partners ought to be the lead researchers or head of cores (Nderitu and Kamaara, 2020). There was concession from some Kenyan partners that they rely on the plan, direction and opinion of their North American partners when it comes to key healthcare projects and research because of their low levels of experience with complex concepts in healthcare not available in Kenya (Nderitu and Kamaara, 2020). This was also implied by a North American partner who observed that the inadequacy in training for the Kenyan partners may inadvertently place them at a lesser position of grant competition compared to other global health researchers (Nderitu and Kamaara, 2020). This may be interpreted to mean that the Kenyan partners are inherently 'inferior' in the partnership and thus assume the Aristotelian description of the expectations of such a 'friend'. On the flipside, the impression about the North-American privilege in the Partnership may be working to their disadvantage. In a way, compared to the Kenyan partners who come into the partnership as researchers, lecturers and physicians, the North American partner career success is more often pegged to their sole role as researchers. According to Tierney *et al*., (2013) there are no 'research faculty tracks' at Moi unlike in North America where faculty can be predominantly in the research track and spend relatively little time in clinical care and teaching. This would more often require that the North American partner gives in extra effort in research engagement whenever the Kenyan partners become too involved in the other aspects of their careers. This could thereby give an impression of domination by the North American partner.

In certain circumstances the Kenyan partners seem like they were contented with the fact that they were working with the North American partners. It favoured their profiles even if the North American dominated the research agenda . It is prestigious working with the North American partner. Their career progression is positively impacted when they work with partners from North America. The notion of the North American domination is sometimes perceived like the natural thing to expect in a 'friendship among unequal parties'. The implication of this is that in north-south partnerships it would be a case of naïve optimism to expect priority setting. Naturally, in such a 'friendship', "the superior person should get more honour, and the person in need, more (material) gain, since honour is the reward of virtue and beneficence, while gain is what ministers to need" (Roger Crisp, 2004). The gain that the inferior partner yearns for includes what the Kenyan institutions and partners in the IU-Kenya Partnership gained, as listed above.

In the early years of the establishment of the IU Kenya Partnership the general struggle that befalls most of the Global North-South partnerships regarding misguided priorities and slow pick-up pace of programs mainly due to historical inequality between the West and the South seems to have characterized the Partnership. These challenges are occasioned by historical trends in global health like the "vertical", siloed approach of disease-specific, donor-funded programs, limited focus on social and structural determinants of health, and poverty reduction strategies, in the design of health interventions and the passive, patient-initiated, facility-based model of care (Mercer, T., Gardner, A., Andama, B. *et al.* , 2018) which are somehow due to setting research agenda from the donor countries' priorities. This is coupled with the history of paternalism in healthcare which still continues to dominate Africa where the agenda of medical experts can easily dominate at the expense of community priorities. This also includes lack of multi-disciplinary approach to healthcare and research where, more often, the health scientists may dominate other equally important academic and research disciplines. A partner from Kenya observed that those in clinical care and research stood better chance of collaboration than those in behavioural and social sciences.[4] Until the 'Social Science Research Network' (SSRN) was integrated in the Partnership, some of the efforts to address health issues in the AMPATH catchment area in Kenya experienced a slow pace. For the over three decades of the existence of the IU-Kenya Partnership, there has been shifts of research concentration in different areas. The first almost two decades' concentration of the Partnership was on HIV/AIDS, but the high pace of change has seen the last decade expand focus on various healthcare issues, including non-communicable chronic diseases, health system strengthening, and population health more broadly (Mercer, T., Gardner, A., Andama, B. *et al.*, 2018). This is attributable to the inclusion of diverse disciplines in the AMPATH Network particularly the social sciences. Out of this effort the AMPATH engagement has moved beyond the traditional disease-specific silos in global health to a model focused on health systems strengthening and population health (Mercer, T., Gardner, A., Andama, B. et al. , 2018) and now the programs are able to address many of the broader dimensions of health care for the community, such as safe water, nutrition, and family preservation, and also have become engaged in related fields such as legal aid, business development, and clinical pastoral education [5] which reflects a holistic approach to health and community wellbeing. This is a positive move towards promotion of community priorities in health partnerships.

Conclusions and recommendations

Priority setting in North-South collaborative research in Africa would need to readjust in due consideration of the power imbalance between partners and the contextual issues in Africa which discern the promotion of holistic approach to healthcare. Drawing from the experience of the 'unequal' IU-Kenya Partnership, the following specific lessons can inform the establishment of priority-oriented partnerships in health research:

1. Each party in the 'unequal' partnership should play their part in the collaborative programs in ensuring that chances of exacerbating inequality and misplaced priorities are minimized. The North American partner who symbolizes the 'superior' friend should strive to familiarize with the existential reality of the Kenyan partners which influences them to make certain decisions in the research projects and partnership programs, understand the local research needs and the African cultural worldviews about diseases and healing that direct research priorities for communities. Finally, the North American partners including the funding agencies, governments, collaborating institutions and individual parties should make the agenda of empowering the global-south partners to be central in the rationalization of partnerships so that they may make marching contributions as the Global North Partners.

[4] David Nderitu (2019. *An Analysis of Aristotelian Analogy of Friendship Among Unequal Parties: The Case of IU-Kenya Partnership*. Unpublished Thesis Moi University, Department of Philosophy, Religion and Theology.

[5]https://www.nafsa.org/professionalresources/publications/collaboratingafrica?impid=hp%3Aie_collaborating_africa%3Arotator%3Amb_2016_09_13

The Kenyan partner, who in this case denotes the 'inferior' party should pursue realistic expectations from collaboration with North American partners and make contributions that promote fairness for the partners and strive to promote collaborative agenda that is at the best interest of the local research communities. The Kenyan government and policy makers ought to ensure that they increase support for development of research in order to uplift and empower local researchers and reduce over-reliance on external donors, for the sake of promoting local priorities in health research.

Also, both partners need to be aware of the dynamism of unequal partnerships in terms of power relations and socio-economic disparities which contribute significantly to agenda setting and progression in the health research collaborations.

2. Global Health research programs need to diversify and engage multi and inter-disciplinary experts and even non-discipline experts in health research in Africa in order to broaden dimensions of community health needs and therefore, set the right priorities for local communities in research.

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