Creating a Charter of Collaboration for International University Partnerships: The Elmina Declaration for Human Resources for Health

Frank Anderson, MD, MPH, Peter Donkor, MDSc, Raymond de Vries, PhD, MA, Ebenezer Appiah-Denkyira, MD, MPH, George Fidelis Dakpallah, MSc, Sarah Rominski, MPH, Jane Hassinger, MSW, Airong Lou, PhD, Janet Kwansah, MBA, RN, Cheryl Moyer, PhD, MPH, Gurpreet K. Rana, MLS, Aaron Lawson, MBChB, PhD, and Seth Ayettey, MBBS, PhD

Abstract

The potential of international academic partnerships to build global capacity is critical in efforts to improve health in poorer countries. Academic collaborations, however, are challenged by distance, communication issues, cultural differences, and historical context. The Collaborative Health Alliance for Reshaping Training, Education, and Research project (funded by the Bill and Melinda Gates Foundation and implemented through academic medicine and public health and governmental institutions in Michigan and Ghana) took a prospective approach to address these issues. The project had four objectives: to create a "charter for collaboration" (CFC), to improve data-driven policy making, to enhance health care provider education, and to increase research capacity. The goal of the CFC was to establish principles to guide the course of the technical work. All participants participated at an initial conference in Elmina, Ghana. Nine months later, the CFC had been revised and adopted. A qualitative investigation of the CFC's effects identified three themes: the CFC's unique value, the influence of the process of creating the CFC on patterns of communication, and the creation of a context for research and collaboration. Creating the CFC established a context in which implementing technical interventions became an opportunity for dialogue and developing a mutually beneficial partnership. To increase the likelihood that research results would be translated into policy reforms, the CFC made explicit the opportunities, potential problems, and institutional barriers to be overcome. The process of creating a CFC and the resulting document define a new standard in academic and governmental partnerships.

International academic partnerships to improve health are increasingly common.[1,2] Successful collaborations create an enabling environment that engages all stakeholders,[3,4] builds trust among partners,[5,6] and builds local capacity to ensure lasting and sustainable gains once the initial period of engagement has ended.[6–9] However, distance,[10] communication,[11] cultural differences,[12] and historical context present significant challenges to the success of these collaborations. For example, in most collaborations between "high resource" and "low resource" settings, it is the collaborators from countries in the wealthier global North that control the majority of the resources, creating inequity in partnership from the outset.[13–18] For an international partnership to function effectively, the motivations, priorities, and definitions of success of all partners must be explicitly understood and transparent.[19–21] Additionally, misunderstandings occur when sensitive issues of authorship, data access, and rights to presentation of data are not explicitly addressed.[22] Successful collaborations create context to build trust among partners,[5,6] to build local capacity ensuring lasting and sustainable gains,[17–20] and to engage all stakeholders.[21,22] Additionally, there is a need for community involvement[23] and long-term, mutually beneficial commitment from the highest levels of each partnering institution.[1,2] The importance of a personal connection between project initiators is a well-documented facet[19,24–27] of successful global collaborations.

In this article, we describe our effort to create the conditions for an equitable collaboration between the University of Ghana (UG), the Kwame Nkrumah University of Science and Technology (KNUST), the Ghana Ministry of Health, the Ghana Health Service, and the University of Michigan (UM) by means of the creation of a partnership document developed and agreed to by all partners. The document was developed in the early stages of the Ghana–Michigan Collaborative Health Alliance for Reshaping Training, Education, and Research, or CHARTER project, funded by the Bill and Melinda Gates Foundation. Designated as a "learning grant," the overall CHARTER goal was to design an evidence-based plan for academic–government collaborative interventions to strengthen the training and deployment of human resources for health in Ghana. The grant followed from a successful 20-year collaboration between the departments of obstetrics–gynecology at UM, UG, and KNUST, which led to high in-country retention of certified postgraduates in Ghana.[1,28–30]

The CHARTER project had four objectives. The first objective (objective 1) was the creation of a document to guide the collaboration; using a play on words, we named this document "*charter*

Please see the end of this article for information about the authors.

Correspondence should be addressed to Dr. Anderson, 1500 E. Medical Center Dr., L4000 WH, Ann Arbor, MI 48109-0276; telephone: (734) 763-2441; e-mail: fwja@med.umich.edu.

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for collaboration" (hereafter CFC). The other three objectives (objectives 2–4) were technical: objective 2 focused on strategies to improve data-driven policy making; objective 3 focused on enhancing health care provider education; and objective 4 sought to increase the capacity for research in Ghana. The goal of the CFC was to establish the principles that would guide the course of the project's technical work and to create an ongoing and reflexive process for examining and, if necessary, redefining how partners work together. Recognizing the many pitfalls in collaborative endeavors between North and South, the CFC was an effort to create a context for balanced partnerships between U.S. and Ghanaian institutions in which current and future projects could thrive.

During the initial stages of the project in 2009, one author (G.K.R.) developed an extensive search strategy of the literature to identify articles describing partnership projects. The literature was evaluated (S.R. and F.A.) to identify issues of collaboration explicitly addressed before implementation of global health research or training programs. We found a number of articles on international academic collaborations (see Supplemental Digital Appendix 1, http://links.lww.com/ACADMED/A215), but surprisingly, we were unable to find an article where the authors systematically described an explicit process to cooperatively define the features of a collaboration put in place before the implementation of a global program. Many of the articles we reviewed concluded that there is great need for collaborators from the North and the South to develop ethical, committed, long-term, sustainable, and representative partnerships. We had hoped to find guidance in the literature for a prospective approach, but given the paucity of publications on how to build successful, ongoing North–South collaborations, we herein describe the process that would guide our collaboration.

Developing the CFC

The development of the CFC was a key initial component of the collaborative work between UM and the Ghanaian institutions. Dedicating an objective to collaboration was an integral part of the proposal. Our previous efforts demonstrated the importance of addressing partnership issues. Because this was a learning grant, creating a context for partnerships to guide a later expansion was critical.

One author (F.A.) identified the "Bamako Call to Action" as a model for our CFC.[31] The Bamako document, presented at the Ministerial Summit for Health Research for Development held in Bamako, Mali, in 2008, was based on prior work of the Global Forum for Health Research. The Bamako Call to Action includes four major sections:

1. "Recognizing that …" [a description of the existing conditions],
2. "Conscious of the Need to …" [a summary of the most pressing needs],
3. "Guiding Principles" [to be adhered to by all parties], and
4. "Commitments" [expressions of commitments to the collaboration measured in terms of contributions of resources (time and money) and willingness to see the project to its conclusion].

All partners agreed that these four sections captured the key dimensions for the basis of the collaboration.

The inaugural meeting of the Ghana–Michigan CHARTER project was held in Elmina, Ghana, February 2 to 6, 2009, with participation of 34 individual collaborators from UM and 32 collaborators from Ghana. Elmina is approximately 70 miles from the capital city of Accra. This retreat-like setting supported full participation, away from the demands of other professional commitments. Three of us (F.A., P.D., and R.d.V.) facilitated a process that allowed all partners to have a voice in the creation of the CFC. All four objectives of the project were discussed at this five-day meeting, with approximately 14 hours for the creation of CFC (4 hours at plenary sessions and 10 hours at various breakout sessions).

Creating the CFC

At the onset of the conference, F.A. presented the concept of objective 1 and P.D. presented the positive and negative experiences of prior international partnerships in Ghana, followed by discussion.

Using the Bamako framework, F.A. created a fillable worksheet to enable participants to submit statements that described baseline situations and assumptions, identify areas of action, set forth principles to guide the collaboration, and define next steps. Participants were given 30 minutes to write their responses. Responses were discussed in plenary, and the worksheets were collected and collated to be discussed in the breakout session dedicated to CFC development.

R.d.V. facilitated a plenary session for brainstorming the principles that should guide the collaboration. This exercise included 52 participants—27 from UM and 25 from Ghana who were organized into six groups—to identify the principles to be used in the work of the CHARTER. They identified 26 separate principles with significant overlap—for instance, both "transparency" and "clarity" were mentioned several times. We identified the 10 most-often-mentioned principles to be used in the CFC.

F.A., P.D., S.R., and R.d.V. then facilitated a group of 17 participants—10 from UM and 7 from Ghana—to complete the CFC draft. In addition to the "top 10" principles, each participant reviewed worksheets completed at the first plenary session and provided a short summary of the key aspects reported in their particular worksheets.

To consolidate these statements to create the CFC, F.A. asked each participant to use the raw material of the worksheets and their own opinions to contribute CFC statements. The group made further clarifications as each phrase was read and re-read. Workshop sessions to complete this process lasted for four hours on days 3 and 4 of the meeting. Using this input, an initial draft of the CFC was developed by the objective 1 team (F.A., P.D., S.R., R.d.V.) and presented at a plenary session on the last day of the meeting. Further comments and suggestions were noted for later inclusion into the document.

In the months after the conference, F.A. and S.R. conducted regular meetings and conference calls with colleagues in Michigan and in Ghana to further refine the CFC. A final draft was circulated in preparation for formal adoption. On November 13, 2009, the document, entitled the "Elmina Declaration for Human Resources for Health: A Charter for Collaboration," was adopted in a formal ceremony at a project meeting in

Ann Arbor, Michigan, and signed by all participants (see Appendix 1).

One participant summed up the process:

> I was impressed at how deliberate the process was that, like you said, there wasn't an MOU [memorandum of understanding] signed and it wasn't just a rubber stamp on the process, but we really struggled with each of the different aspects.

Evaluating the Effects of the CFC

At the Ann Arbor meeting, participants were invited to interviews and focus group sessions to discuss the CFC. This evaluation process was approved by the UM institutional review board. The scripts for the interviews and focus groups were developed by the objective 1 team and included questions about how structural (e.g., the organization of the project and the institutions involved, patterns of compensation) and cultural (ideas about authority within research teams, the valuing of research) issues influenced the work of the project, and about how this project—guided as it was by the CFC process—differed (or not) from other collaborative work experienced by the participants. We gathered responses from 37 participants: 17 members of the project were interviewed, and 20 participated in one of three focus groups. All interviews and focus groups were digitally recorded and transcribed. We used NVivo 9.0 (QSR International, Melbourne, Australia) to help identify key themes and concepts within the data.

Participants recognized both the value of the CFC and the process used to develop it. Although the charter was newly ratified at the time of our interviews, it became clear that the attention paid to its development had a profound influence on the collaboration. Three major themes emerged from our analysis: (1) the unique value of the CFC; (2) the influence of the CFC process on patterns of communication, on the value given to different voices, on commitment to the project, and on the creation of a context for research and collaboration; and (3) ongoing challenges.

The unique value of the charter

Several participants highlighted the distinctiveness of the CFC, noting the overall value of a charter for guiding collaborative projects. Commenting on past collaborations of which she had been a part, one person articulated limits with simple agreements or contracts.

> We've had quite a few collaborations … and even though it was institutional, as I said, it didn't belong, just signing of agreements and everybody expected to buy into it. So you find that, one, two years down the line, we don't seem to agree on a lot of issues. It brings out a whole lot of confusion because we didn't sit to agree on the basic issues at the beginning. So two years down the line everybody has a different agenda.

Another person emphasized the need for a charter-type document, noting how cultural differences not only between societies, but also between disciplines, can be a barrier to interdisciplinary work.

> When those individuals have been trained differently, professionalized differently, socially and culturally trained as professionals in a different fashion, then I think that makes it all the more difficult to do that kind of interdisciplinary work.

Participants also felt that the CFC helped counteract the tendency for countries from the North to dominate countries from the South.

> It's not unusual for institutions in developed countries to—I mean, to put it very bluntly—to have a colonialist mentality, you know, when it comes to these collaborations. But I think that is not the case as far as this collaboration is concerned.

A U.S. participant agreed:

> So it's not just us going over there, and collecting data and just taking, taking, taking, but that they also reap the benefit on their side, whether they're building their institutions and they're building their infrastructure at the same time. That will be success.

The influence of the charter process

Communication. We heard a lot about the way the CFC process shaped this particular collaboration. When asked how this collaboration was different from others, several participants described improved communication and transparency between parties:

> I will say that this is a bit more transparent than a few other collaborations I've worked on, just a bit more transparent. Communication is much better among collaborators and among researchers and among members of the team.
>
> I think that's been one of the goals of this project, is to try to optimize transparency among the groups and between the groups—I think we've been pretty successful in that. That's built a certain level of trust, I think that's been good.

In the same vein, one participant from Ghana said:

> I must say that the University of Michigan has been very transparent. Right from the word "go," um, they told us. They allowed us to see the budget.

Respect for different voices. As with communication, the CFC process was credited for creating respect for all members of the team.

> It wasn't a command filtered down through the ranks. It was—let's all sit, although the general is sitting down, he is welcoming everybody in the decision-making process. And that was a difference.
>
> The fact that we are all prepared to talk to each other and we talk with openness, we talk with the demeanor of equals, peers.

Commitment to the project. Better communication and a shared respect increased commitment to the project overall. Although "commitment" is not a stated principle in the CFC, several participants commented that this collaboration seemed to promote a higher level of commitment to the project when compared with other collaborations:

> Yes, looking at the level of commitment and interest of members of the project, I think it [made] a difference. And if you look at the way it was adopted, everybody was made to sign. You see, unlike different charters or documents where it is between two leaders—I sign and it is binding on all other members—every member of the project signed, so you have committed yourself.
>
> Well I think it has, it demonstrates commitment more than just involvement. It's institutional commitment. These people are doing this *on behalf of* the institution, so back to that individual versus institution. These people came together and did it.
>
> The mere fact that the heads like the provosts and the deans were part of this project, I think, has helped some of us to get committed."

Creating a context for collaboration. Respondents also indicated that the CFC process created a context that allowed for higher levels of trust and improved relationships, not just between

international partners, but *within* the cooperating institutions.

> And it's gone beyond just teaching. And the two departments—we see that we have a common responsibility to the nation. And again, this collaboration since it started, you see, that feeling is evolving … at a broader institutional level we see that we [the ministries and the universities] have a common responsibility to the nation. We may be pulling in different directions, but ultimately it is towards the agenda of the nation. So that now, for instance, the ministry of health people—we are able to talk to them straight in the face.

Another participant said:

> One of the successes of this whole exercise will be that, at the end of it all, not only will there be continuing interaction with Michigan, but for those of us coming from Ghana, there will be greater collaboration amongst ourselves.

And again:

> What's happened as a result of this project is that people—we in Ghana—have started communicating with each other far better than we ever did. It's like, we're not even there. This is somebody from the ministry and he said, "I always felt like it was hard for me to go over to the medical school at the University of Ghana. But now … I can just call him up, I go to his office, we have conversations. But until this project we never did that.

This finding, that the charter improved intranation as well as internation communication, had one participant calling for the use of a CFC process in other projects.

> With this project you see two universities—two major universities—and the ministry of health actually collaborating, sitting down to talk. Now it's so easy to walk into … office to discuss issues of common interest with him, likewise the others. And I think that that has, for me, it's really opened for me some opportunities to work better, in Ghana. And I think other projects should look at this and replicate it.

For several participants, this improvement in the research context was seen as the most successful part of the project.

> And I think what was especially valued in this project is that the ministry has been involved in the generation of data. I think that's a really key element of success. I don't think it happens enough in projects.

> So I feel like for me personally, if nothing else comes out of this than sustained, long-term research collaborations, I will see that as successful. Publications are nice, yes. Future grant funding, great. But relationships to me are what matter.

> What counts as a success is the cooperation between the Ministry of Health, Kwame Nkrumah University of Science and Technology and the UGMS and then the schools of nursing from Kumasi and Accra all come together sitting at a round table and making discussions. This, and agreeing to a common program. This I think is a success.

Continuing problems

Of course, not every problem in the collaboration was solved by the CFC. We also heard about problems that remain. For example, although every effort was made to be sure that all voices were heard in the creation of the document, some participants noticed that the process was directed by UM.

> And I think that what it does is that Michigan gets too much prominence as opposed to our Ghanaian partners. Our Ghanaian partners should actually be chairing the meetings.

And perhaps it is possible to have too many voices.

> The reality is that every new person who comes in says, "Have you thought about it from the sociological perspective?" "Have you thought about it from the public policy perspective?" "Have you thought—?" which is great. Don't get me wrong. That's very valuable. But then you end up sort of rethinking things that you thought you'd already decided.

Another respondent commented on problems with infrastructure.

> The lag in e-mails and phone communications and … we need to say something by such-and-such a date, but because we don't have electricity, you can't send it, how do we deal with that? I don't think we've talked about those issues enough.

Another participant commented in different hierarchies in Ghanaian and U.S. universities.

> We've noticed that hierarchy is different as well. The fact that we have two provosts here, it's hard for us to imagine our provosts or deans going over to Elmina and sitting in break-out groups.

Furthermore, CFC agreements cannot erase cultural differences.

> I think that that speaks to me very clearly when I was in Ghana, that the American culture is a very impatient culture [laughter around]. We're used to getting exactly what we want exactly when we want it. And the Ghanaian culture is much stronger in that you're very patient.

This brief qualitative assessment shows that the coincident process of developing the CFC resulted in a project implementation that was richer than just implementing a technical program alone.

Discussion

In this article, we describe the development and initial effects of creating a CFC as part of a program implementation among partners in the United States and Ghana to improve educational and research capacity. We found that the process of developing the CFC had a great impact on the course of the entire project.

The process of proposing and implementing the CFC infused the project with partnership considerations and created a context where the project included more than educational activities and scientific output. The implementation of the technical components occurred in a context of first articulating and then applying principles and partnership considerations. Because these processes were so tightly melded, it is difficult to determine the effects of the CFC per se, but the comments from interviews clearly indicate that incorporating this process was effective and enhanced the project to such a degree that it now seems to be a necessary component of any further collaboration. To ensure success, careful consideration from both sides as to the nature and outcomes of a collaborative project is necessary.

The development and adoption of this collaboration document created a context where a series of planned, data-driven interventions in health policy became an opportunity to engage in open dialogue to develop a mutually beneficial partnership. It allowed and encouraged all participants to not only "get the work done" but also to be very conscious of *how* the work was being done. By making explicit the potential problems of international work and the inter- and intranational institutional barriers to successful collaboration, the CFC makes it more likely that research results will be used to create policy reforms.

A key to the success was that the CFC was suggested at the time of project proposal. Both human and monetary resources were devoted so that this document could be evoked and cocreated by all partners. Creating the CFC during project design ensured transparency and integrity in identifying common needs, priorities, opportunities, barriers, and commitments. The broad participation from the outset exposed a large number of people to the process and is one major reason why this document has the potential to continue to inform new collaborative projects beyond the grant period. Prior experiences made us aware that smooth communication would be impeded by limited access to the Internet, e-mail and phone, cultural and structural differences in organizations, and styles of work. The process of creating the CFC made these problems explicit, thereby reducing levels of frustration and protecting important collaborative relationships. As communication failures were expected, alternative solutions were actively and, in some cases, preemptively sought.

The charter's emphasis on communication improved interactions not just between collaborators from different countries but also between collaborators *within* each country. Collaborators working at different institutions in Ghana began to communicate in more transparent and productive ways. The explicit discussions about the need for open communication during the CFC development process resulted in acknowledgment of infrastructure and institutional barriers. Awareness and correction of these "in country" barriers then allowed the results of the research to be quickly translated into suggestions for policy reforms.

Now that it exists, the CFC serves another function as a touchstone for new collaborative projects. This document obviates the need for one charismatic person to lead the partnership. Participants can refer to "charter principles" to frame conflicts or create new proposals and help future collaborators understand the considerations for project success. High-level institutional representation in the creation of the CFC served to assure partners of institutional commitment as well as the protection of their interests.

Continuous exploration of how each statement of the CFC can or cannot be realized will inform future revisions of the document and will further define elements of effective partnership. Anecdotal reports from CHARTER project participants suggest that this process has been used in the creation of other global partnerships.

The process of creating a CFC and the resulting living document helps define a new standard in academic and governmental partnerships and can be applied and adapted to other global programs. It is our experience that a proactive process engaging all participants will enhance trust and prevent productive collaborations from being disrupted by the predictable, but avoidable, problems that beset international work.

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Dr. Anderson is associate professor of obstetrics and gynecology and departmental director, Global Initiatives, University of Michigan, Ann Arbor, Michigan.

Dr. Donkor is professor, Department of Surgery, Kwame Nkrumah University of Science and Technology, College of Health Sciences, Kumasi, Ghana.

Dr. de Vries is professor, Center for Bioethics and Social Science in Medicine, Departments of Medical Education, Obstetrics & Gynecology, and Sociology, University of Michigan, Ann Arbor, Michigan, and visiting professor, CAPHRI School for Public Health and Primary Care, Maastricht University Medical School, Maastricht, The Netherlands.

Dr. Appiah-Denkyira is director of human resources, Ghana Ministry of Health, Accra, Ghana.

Mr. Fidelis Dakpallah is director, Policy, Planning, Monitoring, and Evaluation Directorate, Ghana Ministry of Health, Accra, Ghana.

Ms. Rominski is research associate, Office of Global Reach, University of Michigan, Ann Arbor, Michigan.

Ms. Hassinger is lecturer in women's studies and research specialist, Institute for Research of Women and Gender, University of Michigan, Ann Arbor, Michigan.

Dr. Lou is research area specialist lead in information science, Office of Enabling Technologies, University of Michigan, Ann Arbor, Michigan.

Ms. Kwansah is senior nursing officer, Policy, Planning, Monitoring, and Evaluation Directorate, Ghana Ministry of Health, Accra, Ghana.

Dr. Moyer is managing director, Global REACH, University of Michigan Medical School, and research investigator, Department of Medical Education, University of Michigan, Ann Arbor, Michigan.

Ms. Rana is global health coordinator, Taubman Health Sciences Library, University of Michigan, Ann Arbor, Michigan.

Dr. Lawson is provost, College of Health Sciences, University of Ghana, Accra, Ghana.

Dr. Ayettey is professor, Department of Anatomy, University of Ghana Medical School, College of Health Sciences, Accra, Ghana.

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Appendix 1

The Elmina Declaration on Partnerships to Address Human Resources for Health From the Ghana-Michigan Collaborative Health Alliance Reshaping Training, Education, and Research, 2009

Preamble: This document is a Charter for Collaboration which describes the partnership between groups working in Michigan, USA and Ghana to improve human resources for health funded by the Bill and Melinda Gates Foundation

The Elmina Declaration on Partnerships to Address Human Resources for Health
From the Ghana-Michigan Collaborative Health Alliance Reshaping Training,
Education & Research (CHARTER) Program
Initiated Elmina, Ghana 2–6 February, 2009
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We, the Ghana-Michigan CHARTER collaborators made up of partners from the Ghana Ministry of Health (MOH), the Kwame Nkrumah University of Science and Technology (KNUST), the University of Ghana (UG) (the three aforementioned heretofore referred to as Ghana) and the University of Michigan (UM),

I. Recognize that

1. Human Resources for Health (HRH) includes doctors, nurses, dentists, pharmacists, social workers, and other health professionals, both formal and informal, that are trained across the country by the Ministry of Health, the Ministry of Education, and the private sector.

1. The burden of disease in Ghana requires a prioritization of HRH initiatives
2. The Ghana-Michigan CHARTER project is a part of a larger HRH initiative in Ghana
3. There are inadequate numbers and an asymmetric distribution of human resources in Ghana due to low numbers trained, urban concentration, and low retention of workers
4. There is potential for growth in human resources for health in Ghana as evidenced by the high percentage of qualified applicants not gaining acceptance into training institutions
5. Technological infrastructure is inadequate to support human resources for health and health service delivery, especially in the rural areas
6. Traditional medicine is an important source of primary care for Ghanaians

2. Opportunities abound in our global community for HRH development

1. Technological advances have promise to improve access to information for health workers and health students in all parts of Ghana, especially in rural areas, to improve education, service delivery, and advance research
2. The private sector has many resources that could be harnessed to improve HRH
3. Millennium Development Goals serve as a guide for research for health and health-related issues
4. Prior experiences are a rich source of knowledge to explore, learn from, and share
5. Our partnerships are dynamic and may change over time; gaining knowledge and moving frontiers
6. We have an active commitment on the part of all partners to work together

3. Partnership and Collaboration are crucial for the Universities' and Ministry's shared mission and common interest in improving health outcomes

1. The improvement of HRH requires "a new partnership" which calls for continuous planning, participation, assessment, and improvement
2. Previous partnerships between Ghana and the University of Michigan have been successful, have led to other partnerships, and will continue to have impact at the community level
3. Universities and the MOH have strategic plans and priorities that need to be considered, respected, and promoted
4. The MOH has made a conscious effort with development partners to reduce verticalization. This project represents one of many development partnerships, and Ghana will work with their partners in a coordinated manner to optimize development and health
5. Health teams include other allied health and health related professionals

4. Barriers exist in the development of partnerships to improve HRH

1. Past partnerships have too often not been fair, balanced, equitable, or sustainable and have led to power imbalances between the Southern institutions and those in the North
2. Barriers to growth of human resources exist, including: training opportunities, availability of housing, local teachers, infrastructure, other social structures
3. The resources for electronic communication are not equal among all partners
4. There are infrastructure barriers: faculty promotion, communication, reporting systems, organizational structures, and managerial systems. Competition and financial structures, including compensation and release time, impact how work is accomplished. Structures of coordination are lacking in many partners
5. Individuals and institutions have histories and culture that bind them together but may keep them from breaking free to new ideas
6. Cultural heterogeneity exists between partners, and when there are failures, it can sometimes be attributed to these differences not being taken into account
7. The historical, social, and political context informs how service delivery and research are conducted
8. Research data are limited and exchange of information between academia and the MOH is inconsistent
9. There is potential for conflict between and within partners
10. Although we share a common language, operational definitions differ. Our common language creates the illusion of communication while misunderstandings still occur
11. Leadership structures can be challenging

II. Conscious of the need to

1. Share experiences in medical education, research, innovative technology, and leadership among all partners
2. Develop and share technological and other educational resources efficiently and effectively
3. Develop resources to optimize and fully utilize education, training, and deployment of HRH
4. Improve the infrastructure for electronic communication, skills training, and clinical care
5. Expand the scope of research and translate research results into policy and educational initiatives
6. Recognize, identify, and involve appropriate HRH workers in the process
7. Expand and decentralize education and training into peripheral health facilities, district, public, and private

8. Develop a national government research infrastructure to fund national health research
9. Articulate principles that guide partnerships to lead to sustainable, mutually beneficial collaboration, namely:

TRUST	***MUTUAL RESPECT***	***COMMUNICATION***
ACCOUNTABILITY	***TRANSPARENCY***	***LEADERSHIP***
	SUSTAINABILITY	

III. Institutional Commitments

In pursuit of our determination to help improve the health of all Ghanaians through our objectives of enhancing education and training, strengthening data for decision making, and increasing capacity for research

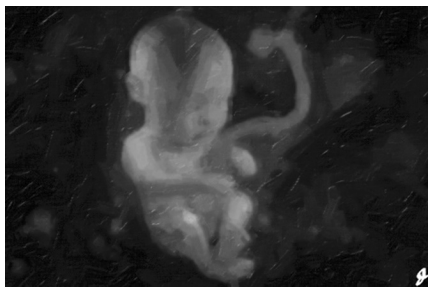
We commit to:

1. Work together to create new knowledge and disseminate our findings through peer-reviewed literature and other means and use the results of our research to inform policy and decision making
2. Providing resources, both human and monetary, for understanding and learning from the partnerships through the development of the Charter for Collaboration document
3. Pursue funding for implementation of the findings from our projects with the overall goal of improving the health of all Ghanaians
4. Pursue and promote the increased use of information and communication technology and develop a communication plan to ensure frequent and open communication for all parties between and within institutions to address the needs of the partnership and objectives, including regular meetings, an accessible website, electronic communication, reports and others
5. Improve and facilitate communication: government to government, government to the academy (universities), academy to academy, and with the private sector, social leaders (churches, NGOs) and the community to maintain a balance in these partner relationships
6. Identify and protect the interests and needs of all partners and work towards meeting these needs
7. Create opportunities for personnel from the universities and Ministry of Health for career development
8. Develop authorship guidelines to promote fair and equitable recognition of individual and group contributions
9. Apply lessons learned from previous collaborations to inform current and future partnerships
10. Be sensitive to issues of gender, ethnicity, religion, and geographic origin
11. Organize and participate in a process to engage all partners currently working in the area of HRH to reduce verticalization and promote lateralization
12. Focus on early recognition of potential sources of conflict and develop a plan for identifying, recognizing, and managing conflicts
13. Evaluate the process on a regular basis and make adjustments accordingly
14. Establish metrics of successful collaborations by which to give feedback to our project
15. Document case examples of collaborative strains and successes

Cover Art
Artist's Statement: Innate Curiosity

Several hours after the induction of labor, I finally stood holding the newborn. It was a complicated delivery, and I couldn't help questioning what had transpired. Why did the mother have to sustain injury and harm during this experience? Why did the newborn have its cord around its neck? Is this the miracle of life? The first delivery during my obstetrics–gynecology rotation raised questions on life, suffering, and universal truths as the baby surfaced for its first breath. Innate curiosity.

I realized in that moment of reflection that we are all equal in suffering and in the boundaries of need—a basic human faith. We are not born equal—that is, we are not born with equal genetic bequest, or physical or intellectual states. We are equal in the sense that we are born to live, endure, and die. Physicians, who often witness the human condition of naked loneliness, know this better than perhaps anyone else on earth. Physicians will have



Innate Curiosity

to help and lead us all, in cherishing and restating that core of human faith.

I have always acknowledged the power of art as an expressive outlet for healing—exploring forms of writing, photography, painting, and digital/graphic design. Medical school has only confirmed my belief that art is medicine, and medicine is art. *Innate Curiosity* serves as my expressive outlet of inquisitive reflection inspired by the thought processes that occurred during and after the events of my first delivery. Among several subtleties in the painting, the colors represent the incarnadine theme of the delivery, while the umbilical cord forms a question mark, representing the curiosity that is innate to us all.

It is imperative to understand that as humans, we are all connected. We are connected in the sense that we are all equal and, therefore, every life is as significant as the next. Despite the uncertainty I felt after that complicated delivery, despite all of my thinking, as I looked at the newborn, and the newborn looked back at me with curious eyes, all my questions were vanquished. Innate curiosity.

Jesse O'Shea

Mr. O'Shea is a fourth-year student, Florida State University College of Medicine, Tallahassee, Florida; e-mail: jgo07@med.fsu.edu.