Exploring the Critical Role of Nurses in Promoting and Achieving Global Health Equity: Challenges, Opportunities, and Strategies for the Future

[1]-Hamidah Moghim Thoghan Alruwaili, [2]-Ohud Mihthaf Okash Alruwaili,[3]-Shuruq Musafiq Fawaz Alruwaili, [4]-Anwar Mehdaf A Alrowaly,[5]-Mariam A Alenzie,[6]-Ahad Mihthaf Akash Alruwili,[7]-Manal Mohammed Alrawway Alruwaili,[8]- Huda Zayed Sutayl Alruwaili,[9]-Tahani Mohammed Mufadhi Alanazi, [10]-Nagah Hadi Sakahil,

[1]Ksa , ministry of health , nursing technician

[2]Ksa , ministry of health , nursing technician

[3]Ksa , ministry of health , nursing technician

[4]Ksa , ministry of health , Midwifery

[5]Ksa , ministry of health , Alyammamh hospital

[6]Ksa , ministry of health , Nursing technician

[7]Ksa , ministry of health , Nursing technician

[8]Ksa , ministry of health , Suwair general hospital

[9]Ksa , ministry of health , Alyammamah hospital

[10]Ksa , ministry of health , Al yammamah hospital

Abstract

Background: Global Health Partnerships (GHPs) play a crucial role in addressing health inequities and are essential for advancing the Sustainable Development Goals. However, these partnerships often grapple with historical disparities and power imbalances, particularly between North and South entities.

Methods: This study employed a critical interpretive synthesis to analyze peer-reviewed literature published between 2010 and 2023, focusing on GHPs. A systematic scoping review was conducted across six databases: Medline, Embase, PsycINFO, CINAHL, Web of Science, and Scopus, using keywords related to global health and partnership evaluations. The selected articles were evaluated based on their relevance to North-South partnerships.

Results: The analysis revealed significant variability in how GHPs were evaluated, with a predominant focus on the operational aspects of Southern partners rather than equitable power dynamics. The literature often highlighted the altruistic intentions of GHPs while neglecting the underlying structural inequities that persist. Key themes identified included the importance of initial collaboration stages, governance challenges, operational transparency, and the need for equitable resource distribution. Notably, the authors associated with these studies were predominantly from the Global North, which may influence the framing of partnership dynamics.

Conclusion: While GHPs have the potential to promote health equity, their effectiveness is often undermined by persistent inequities in power and resource allocation. A more equitable approach is necessary to ensure that GHPs genuinely address the needs of disadvantaged populations. Future research

should emphasize critical power analyses and the incorporation of Southern perspectives in the evaluation of GHPs.

1. Introduction

Partnerships include the collaboration of two or more organizations working towards a shared objective. Global health partnerships (GHPs) are extensively advocated as a means to enhance health systems and attain the Sustainable Development Goals by supporting research, offering technical assistance or service support, engaging in advocacy, or providing financing [1-4]. Funding methods of governmental, corporate, and charitable entities often need or encourage them. These collaborations exist within academic and professional domains that often include an idealistic commitment to human rights and the promotion of equality [5, 6]. They encompass various types of 'partners' (i.e., individuals or entities constituting the partnership), including government agencies, non-governmental organizations (NGOs), corporations, universities, professional associations, and philanthropic organizations—each perceiving the potential advantages and necessity for GHPs in distinct manners. Although several exemplary GHPs exist, they all grapple with the enduring consequences of historically inequitable North-South political and economic relations. Significant economic and health disparities place North-South Global Health Partnerships in a predicament of fundamentally unequal allocations of resources and authority [7,8].

Critical scholarship on Global Health Partnerships (GHPs) highlights the potential for exploitation and harm, which may exacerbate the inequities they aim to address [9]. This occurs, for instance, by disproportionately favoring the interests of more privileged partners, thereby straining the already limited material and human resources of less privileged counterparts, or by perpetuating neocolonial power dynamics within nations [10-12]. GHPs have generally channeled Northern resources, interests, and priorities towards initiatives in the Global South [13,14]. Current Global Health Partnership models, influenced by intricate colonial legacies, originated from post-World War II international institutions that upheld "inter-colonial health systems" and typically entailed the transfer of personnel and health-related resources from the North to the South, amidst significant overall Northward flows of extracted wealth. The implementation of neoliberal economic reforms in the latter part of the twentieth century restructured the global political economy by promoting unregulated 'free' markets, diminishing trade barriers, reducing welfare states, and encouraging privatization, thus altering the terrain of global governance [15,16]. Interest in efficiency, efficacy, evidence, and assessment increased, leading to the establishment of new multilateral financial mechanisms to direct Northern resources to Southern beneficiaries, often under certain conditions. Partnerships continued to be a fundamental aspect of universities, NGOs, and international organizations, often linked to government development aid or trade resources [17-19].

This flow of resources, typically characterized as 'beneficial,' often conceals how partnerships may perpetuate disparities in resources and power, eventually prioritizing the needs and interests of already privileged partners over the communities they are intended to assist. Equity in global health is widely recognized as essential for promoting the field's aspirational goals, yet the alignment of equity-seeking intents with actionable outcomes remains challenging and uneven [18-20]. Understanding the intricate sociopolitical, economic, and historical settings of GHPs involves a meticulous examination of how these partnerships are characterized and evaluated to discern the presence of equitable concerns [21]. This critical interpretative synthesis (CIS) used an equitable perspective to analyze the focal points of individuals engaged in GHPs, particularly the elements, activities, processes, or results they deemed significant. This review contributes to comprehensive mixed methods research designed to provide a practical, equity-focused tool to assist those engaged in GHPs in addressing complex equity challenges.

2. Methods

Our data collection was derived from a scoping examination of peer-reviewed literature published between 2010 and 2023, indexed in six databases: Medline, Embase, PsycINFO, CINAHL, Web of Science, and Scopus. The scoping study, specifics of which are published elsewhere [22], used search keywords pertinent to global health and partnerships, including their evaluation, quality, and attributes. Articles were evaluated based on inclusion and exclusion criteria, specifically picking those that directly pertained to a North-South partnership evaluation rather than a project assessment. Partnerships between governments were omitted.

3. Results

Methods for evaluating GHPs included qualitative techniques [23,24]; literature reviews [25,26]; mixed methods [27]; realist syntheses and evaluations [28]; grounded theory [29,30]; social network analysis [31]; and survey research using logistic regression [32]. Theoretical underpinnings, methodological techniques, and participant involvement in a GHP exhibited considerable variability. Notably, while there was a common emphasis on evaluating partnerships, stories more often highlighted the outcomes-based performance of Global South partners rather than the operational aspects of the relationships themselves.

The authorship of articles intrigued us as an indicator of who is bestowed with power or accountability for reporting on a GHP. Among the 29 articles analyzed, which included 152 authors with identifiable primary geographic affiliations, 120 authors (79%) were associated with institutions in the global North—specifically Canada [33-37]; Europe (Switzerland, Ireland, the United Kingdom, Germany, the Netherlands) [30, 31, 38]; the United States [29, 33, 34, 36]; and Australia [38]. Conversely, 32 authors (21%) were affiliated with institutions in the global South, including Kenya [40], Nepal [41], Rwanda [42], and Uganda [43].

4. The situations around their GHPs

The portrayal of GHPs was significant to our research as it reveals the assumptions behind the connections, structure, and nature of the partnership, as well as the authors' views of the validity and purpose of GHPs [11, 12]. Authors exhibited considerable diversity in their framing of the function and context of their GHPs. GHPs were often centered on specific themes related to research, capacity-building, clinical, or healthcare issues. Although historical and political North-South dynamics were seldom analyzed as significant factors in Global Health Policies (GHPs), they were often depicted as intricate and marked by imbalances in power and resources, as noted in one article: "Relations between different actors with varying degrees of power and influence." The extent to which such disparities were elucidated also differed. In several instances, Southern resource limitations manifested as an inexplicable absence of capability or infrastructure [44]. Some participants specifically recognized global health disparities as significant factors in their Global Health Programs (GHP) [32, 34, 35, 37], with some individuals asserting that addressing these imbalances was fundamental to their GHP initiatives.

Our study highlighted three notable instances of equity-seeking evaluations or methodologies for evaluating GHPs. Herrick et al. investigated the intricate 'binds' associated with GHPs in environments characterized by significant discrepancies. The ethnographic study revealed that several participants experienced a conflict between their conviction that collaboration was virtuous and their dismay at their inability to implement the necessary adjustments in a resource-deficient environment. They finished their study by juxtaposing the idealized perception of partnerships with the chaotic and inequitable reality of Global Health Partnerships, which often permit or disregard significant structural disparities across partners. Murphy et al. acknowledged inequities and detailed the comprehensive involvement of Southern researchers and research users in creating a partnership evaluation framework centered on equity and power [45]. Ridde and Capelle [23] positioned North-South Global Health Partnerships (GHPs) as a strategy to tackle global equity issues, responding to the 10–90 gap, which denotes the disproportionate allocation of 10% of research resources to challenges affecting 90% of the global population, and the necessity for capacity building [23]. Their findings underscored the manifestation of disparities in GHPs, incorporating

remarks from Southern researcher interviewees regarding the propensity of Northern researchers to 'infantilize' their Southern counterparts while accentuating the necessity of conducting work that bolsters solutions required by collaborators in the South [23].

Global Health Partnerships (GHPs) were often depicted as intrinsically advantageous and altruistic, with personnel and financial resources inevitably directed from the global North to projects implemented in the global South. Leffers and Mitchell [46] started their grounded theory research by delineating nurses' "extensive history of service to the global community," whereby nurses provide "direct nursing care to individuals in global contexts or engage in faculty-led service-learning initiatives" in host environments. The terms 'visiting nurses' and 'community host partners' are used without clarification of their identities or origins, leading readers to conclude, towards the conclusion of the essay, that 'community host partners' only pertained to Southern contexts.

Moreover, the influence of corporate power in GHPs was often accepted and legitimized, typically via the support of the private sector's contribution to enhancing effectiveness in global health. Thiessen et al. [42] supported corporate involvement in a GHP by arguing that "the rationale for collaboration is that the private sector can attain superior efficiency through experience and innovative systems." Issues associated with public-private partnerships (PPP), including the possibility of conflicts of interest, were periodically identified [47], although the validity of the PPP model remained unchallenged. An illustrative article emphasizes the extractive sector's role in addressing maternal health issues in Papua New Guinea while neglecting to address the sector's substantial profit extraction, as well as its contributions to extensive environmental degradation, violence, and sexual violence.

5. Characteristics of GHPs

The examined characteristics of GHPs exhibited significant variability, including both informally or qualitatively observed interpersonal and relationship dynamics, the attainment of measurable population health indicators, and logistical reporting aspects (e.g., capacity to get financing in competitive situations). The authors mostly focused on the advantages of GHPs. Numerous publications examined the literature on partnership hazards or failures before transitioning to a success-oriented case study, with little focus on issues, inconsistencies, or adverse outcomes. The majority of writers evaluated elements of partnership processes (n = 23), including decision-making and priority-setting, whereas a subset of these also examined results (n = 8). All thirty publications exhibited a degree of focus on the interpersonal experience associated with participation in GHPs. Numerous studies identified relationship elements, including mutual trust [28, 36, 37, 42, 45, 47], respect, and understanding [28, 36, 47], as fundamental to their conclusions. Certain writers explicitly articulated the significance of cultivating personal ties and friendships in GHPs [28, 30, 39, 41]. In addition to the aforementioned relational dynamics, our analysis discerned five elements that authors deemed essential to effective Global Health Partnerships (GHPs), warranting careful consideration or evaluation (elaborated upon below): (a) initial stages of collaboration; (b) addressing decision-making, procedural, or governance challenges; (c) overseeing the execution of GHP activities; (d) monitoring performance and outcomes; and (e) focusing on inclusivity issues.

6. Initial stages of collaboration

Numerous writers identified the first stages of collaboration as important to the development of GHPs. Authors emphasized the significance of establishing formal collaboration agreements, such as memoranda of understanding, or strategic plans [28, 30, 34, 37, 48]. Numerous writers have articulated that the early formation of common values, objectives, purpose, and vision within the partnership is fundamental [31, 33, 36, 39, 46, 48]. Numerous writers underscored the need for prioritization, accentuating the significance of congruence between the goals of each Global Health Partnership (GHP) partner and local priorities [28,29,30, 36, 38, 40,41,42, 47]. In some instances, this convergence was particularly seen between GHPs and the national health plans of partners in the Global South [29]. In the realm of GHPs for research, one study advocated for feasibility studies [39] during the partnership development phase to evaluate stakeholders' interests, concerns, and readiness to engage in a research collaboration. Others addressed

feasibility indirectly, emphasizing the need to secure sustainability and enough resources and finances to facilitate the fundamental operations of a GHP.

7. Addressing challenges related to decision-making, procedural matters, or governance

The features highlighted in GHP evaluations that need addressing regularly pertain to governance procedures, including decision-making, authority, and responsibility within partnerships. Herrick et al. [40] characterized the governance and partnership processes of GHPs as intrinsically complex and rife with inconsistencies. The historical transition in global health collaboration has evolved from concentrating on particular infectious diseases to emphasizing good governance and partnerships, aimed at ensuring accountability, empowerment, and responsibility among all parties involved. This partnership is perceived as both a method and an objective for developing a more resilient health workforce in southern nations while also providing advantages to northern (or increasingly southern) partners. They analyzed complex dilemmas, or 'binds', arising from the unequal allocation of resources between the global North and South, observing that Northern funding policies and norms, constrained by budget limitations, resulted in neglected contextual realities, restricted sustainability, and insufficient responsiveness to the needs of Southern partners.

8. Overseeing operational facets of GHPs

Numerous publications evaluated or underscored the need to focus on the daily operational activities of GHPs. Authors emphasized the significance of openness in routine communications [32, 55, 58] and in resource allocation [28, 33, 47, 52, 54]. The authors focused on management techniques, including the development of work plans with assessment and reporting methods [30, 42, 50, 57], as well as a clear comprehension of daily goals [37]. Another significant operational concern highlighted by the authors was the need for equitable and fair pay that acknowledges the efforts of personnel and collaborators. In research, the authors highlighted the need for frank discourse around per diems for capacity-building activities, revealing an unpleasant dilemma. They contended that while Southern partners could forfeit pay to engage, their professional responsibilities for ongoing competence should incentivize involvement rather than reliance on per diem expectations [40].

Certain writers emphasized the significance of financial responsibility and transparency [50]. Authors in this and similar papers mostly concentrated on the beneficiaries of assistance (i.e., Southern partners), suggesting a propensity for uneven examination of the results or performance of one group of partners. Bruen et al. [50] provided valuable perspectives on accountability challenges in GHPs that include interactions and individuals possessing differing levels of authority and influence.

9. Focusing on performance and effects

Partnership performance and effects were often reported imprecisely, without differentiation between performance and benefits, as well as clear definitions of what constitutes 'success.' No uniform standards or indicators of 'effective' or 'successful' GHPs were discerned. Only one article [31] offered a clear description of what constitutes a successful GHP, asserting that "we understand 'performance', 'success,' and 'effectiveness' in terms of the problem-solving capacity of partnerships to address the issue they aim to resolve." Yarmoshuk et al. [46] contended that the examination of partnerships and their constraints often lacks thoroughness. They scrutinized the validity of implementers authoring their GHPs due to concerns regarding conflicts of interest and positivity biases prevalent in academic literature, particularly in a period marked by a notable rise in the use of positive descriptors such as "innovative" in scholarly articles, likely driven by the pressures of publication and the necessity to promote outcomes. Although a universal definition of success did not materialize, the literature often suggested that 'success' encompasses advantages for people, organizations, and communities, while providing insights into the effective functioning of GHPs. The majority of publications highlighted challenges, conflicts, or dilemmas in GHPs, with few formal procedures found to facilitate their navigation.

In general, we observed that writers focused less on the dynamics between Northern and Southern partners and more on the performance of the Southern project and its many local players. Some writers

explicitly disregarded the viewpoints of their Southern counterparts, asserting that "unfortunately, interviews with nurses outside the United States were constrained by logistics" [56]. Authors of another publication conducted comprehensive case study evaluations of seven nations financed by the GHP, concentrating only on the execution of various projects and the partnerships in each instance, without evaluating the North-South collaboration [58]. The authors' hypothesis that GHPs include a resource movement from North to South seemed to align with an increased focus on the operational activities conducted by the Southern partners. In a separate article [28], employing a collaborative governance framework for the evaluation of a GHP, the authors provided an analysis from a "Northern" perspective, detailing relationships and relational concepts (e.g., 'trust') while omitting the Southern partners, identified as the primary beneficiaries of the partnership, from their assessment. They advocate for prioritizing Northern perspectives as a means to "enhance the involvement of 'Northern' institutions in recognizing the significance of such collaborations."

Conversely, among the scholars that examined relationships in GHPs more directly, the results mostly concentrated on the behaviors and attitudes of Northern partners. Sandwell et al. [44] investigated the experience of participating in a GHP and highlighted the significance of enduring human and organizational connections, citing 'interpersonal rapport' and 'lightheartedness' as factors enhancing the partnership experience. A certain set of scholars [38] highlighted the inclination of Northern partners to articulate the advantages or achievements of partnerships based on their contributions, whereas Southern partners tended to convey appreciation for the opportunity. During their discourse, they revisited this issue, observing that Northern partners were "incapable of recognizing numerous advantages," hence posing a challenge to the survival of the collaboration. The authors propose the need to question the beliefs of advantages regarding equity [38].

Financial sustainability and the growth of partnerships were seen by some as indicators of success or causes of failure [39]. El Bcheraoui et al. [49] concentrated on the effective attainment of quantitative metrics regarding maternal mortality and other health outcomes, along with process-related "drivers of success." The article, while highlighting the importance of evaluation and learning, primarily focuses on promoting competition among Latin American nations, positing that partners' apprehension of diminishing their reputational standing with neighboring countries could serve as an innovative strategy to enhance the efficacy of global health initiatives. Opportunities for career advancement, skill enhancement, and education were often identified as hallmarks of effective Global Health Partnerships (GHPs). In an essay, the authors contended that an augmentation of "funds, volunteers, prestige, awards, and international visibility" [40] facilitated by the West African Ebola epidemic "solidified the partnership." Visibility was characterized as a reflection of the value and significance of a GHP, with authors citing an interviewee from their extensive mixed-methods study [46] who stated, "Because we were providing care to people with AIDS, our profile increased as we participated in the establishment of the clinics." Herrick et al. [31] similarly critiqued the notion of academic 'success', highlighting the visibility produced by the Ebola crisis and its influence on the competitive incentive frameworks within academia and associated institutions, wherein a significant human tragedy can paradoxically offer career-enhancing prospects for researchers and healthcare practitioners.

10. Constraints and contextualization of findings

This CIS included a methodical review of literature documenting evaluations of North-South GHPs. Our analysis is limited to the material provided by the authors in their publications since we could only examine what was documented. Consistent with prior research on effective strategies for promoting equity action [12], we meticulously analyzed articles to determine whether and how authors contextualized GHPs within the framework of significant economic and health disparities, as neglecting this aspect may lead to the oversight or normalization of inequities. This ruling reinforced the presumption that considering the worldwide distribution of power, resources, and money, North-South GHPs need to promote equitable initiatives, irrespective of the original goal behind the partnership's formation. This collection of articles exhibited significant heterogeneity in the types of items ascribed value in GHPs, with few definitions

provided. Publication policies and standards often limit the extent to which writers may articulate their beliefs, attitudes, or viewpoints, resulting in publications that may not accurately represent the authors' equality objectives or actions [12]. Due to the insufficient focus on critical power analysis in partnerships characterized by established imbalances between the North and South, it is impossible to evaluate whether any Global Health Partnerships resulted in inequitable or ineffective collaborations. These factors limited the extent of our analysis while highlighting the necessity of promoting explicit acknowledgment of how GHPs address equity, power, and inclusion, especially given the extensive and enduring global disparities in the allocation of power, resources, and wealth.

11. Conclusion

GHPs exist at a multifaceted junction of personal motivations, political economics, sociopolitical histories, financial and educational possibilities, and significant health and social disparities that endure both within and across nations globally. The increasing interest in equity concerns in global health transcends the specific emphasis of Global Health Programs (GHPs) to include their operational effectiveness in promoting equality. Our results indicate a need for methods that recognize and analyze the equality implications of all dimensions of partnership, both formal and informal. GHPs may positively influence the determinants of equality if they are implemented with deliberate consideration of power dynamics and the inequalities inherent in North-South collaborations. Understanding that the fundamental causes of health disparities, both domestically and internationally, stem from the inequitable allocation of power, resources, and income, matters of equity in Global Health Policies include assessments of fairness and acceptability, as well as the identification of concerns that require intervention. The lack of critically reflective analysis of relational dynamics and power within Global Health Partnerships (GHPs) indicates a need for tools that facilitate active and equity-informed collaboration among all stakeholders, while amplifying perspectives that may otherwise be marginalized.

References

1. Kelly E, Doyle V, Weakliam D, Schonemann Y. A rapid evidence review on the effectiveness of institutional health partnerships. Glob Health. 2015;11(1):48.
2. Herrick C. The strategic geographies of global health partnerships. Heal Place. 2017;45:152–9.
3. WHO Regional Office for the Americas. Partnership for Health Development (Background paper) [Internet]. Washington, DC; 2008. Available from: https://www.paho.org/hq/dmdocuments/2008/Partnerships_Bkgnd_Document.pdf
4. Ritman D. Health partnership research and the assessment of effectiveness. Global Health. 2016;12(1):43.
5. Ooms G, Hammonds R, Decoster K, Van Damme W. Global health: What it has been so far, what it should be, and what it could become. Antwerp; 2011. (Studies in Health Services Organization & Policy). Report No.: 2
6. Koplan JP, Bond TC, Merson MH, Reddy KS, Rodriguez MH, Sewankambo NK, et al. Towards a common definition of global health. Lancet. 2009;373(9679):1993–5.
7. Millet H. Ukombozi means liberation: a case for decolonizing Global Health research, methodology, and praxis: ProQuest Dissertations Publishing; 2019.
8. Came H, Griffith D. Tackling racism as a "wicked" public health problem: enabling allies in anti-racism praxis. Soc Sci Med. 2018;199:181–8.
9. St-Amant O, Ward-Griffin C, Berman H, Vainio-Mattila A. Client or volunteer? Understanding neoliberalism and neocolonialism within international volunteer health work. Glob Qual Nurs Res. 2018;5:2333393618792956.
10. Hanson L. From reflexivity to collectivity: challenging the benevolence narrative in global health. Can Med Educ J. 2017;8(2):e1–3. Crane JT. Scrambling for Africa: AIDS, expertise, and the rise of American global health science. 1st ed. Ithaca: Cornell University Press; 2013.
11. Brisbois B, Plamondon K. The possible worlds of global health research: an ethics-focused discourse analysis. Soc Sci Med. 2018;196(Supplement C):142–9.

12. Brisbois BW, Spiegel JM, Harris L. Health, environment and colonial legacies: situating the science of pesticides, bananas and bodies in Ecuador. Soc Sci Med. 2019;239:112529.

13. Greene J, Thorp Basilico M, Kim H, Farmer P. Colonial medicine and its legacies. In: Farmer P, editor. Reimagining Global Health. 1st ed. Berkeley: University of California Press; 2013. p. 33–72.

14. Birn A-E. The stages of international (global) health: histories of success or successes of history? Glob Public Health. 2009;4(1):50–68.

15. Brown W. Undoing the demos: Neoliberalism's stealth revolution, vol. 1. Brooklyn: Zone Books; 2015. p. 297. Labonté R, Stuckler D. The rise of neoliberalism: How bad economics imperils health and what to do about it. Vol. 70, Journal of Epidemiology and Community Health. England. BMJ. 2016:312–8.

16. Labonté R. Reprising the globalization dimensions of international health. Glob Health. 2018;14(1):49–54.

17. Plamondon K, Bisung E. The CCGHR principles for Global Health research: centering equity in research, knowledge translation, and practice. Soc Sci Med. 2019;239:112530.

18. Nixon SA, Lee K, Bhutta ZA, Blanchard J, Haddad S, Hoffman SJ, et al. Canada's global health role: supporting equity and global citizenship as a middle power. Lancet. 2018;391(10131):1736–48.

19. Plamondon K, Bottorff JL, Graham ID, Caxaj CS. The integration of evidence from the commission on social determinants of health in the field of health equity: a scoping review. Crit Public Health. 2018;December:14 pages.

20. Dixon-Woods M, Agarwal S, Jones D, Young B, Sutton A. Synthesising qualitative and quantitative evidence: a review of possible methods. J Heal Serv Res. 2005;10(1):45–53. Available from: http://hsr.sagepub.com/content/10/1/45.full.pdf.

21. Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J, et al. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. BMC Med Res Methodol. 2006;6(1):35.

22. Sparke M. Unpacking economism and remapping the terrain of global health. In: Kay A, Williams OD, editors. Global Health governance: crisis, institutions and political economy. New York: Palgrave Macmillan; 2009. p. 131–59.

23. Ridde V, Capelle F. Global health research challenges with a north-south partnership. Can J Public Heal. 2011;102(2):152–6.

24. Dean L, Njelesani J, Smith H, Bates I. Promoting sustainable research partnerships: a mixed-method evaluation of a United Kingdom-Africa capacity strengthening award scheme. Heal Res Policy Syst. 2015;13:1–10.

25. Upvall MJ, Leffers JM. Revising a conceptual model of partnership and sustainability in global health. Public Health Nurs. 2018;35(3):228–37.

26. Yassi A, O'Hara LM, Engelbrecht MC, Uebel K, Nophale LE, Bryce EA, et al. Considerations for preparing a randomized population health intervention trial: lessons from a south African-Canadian partnership to improve the health of health workers. Glob Heal Action. 2014;7(1):23594.

27. Steenhoff AP, Crouse HL, Lukolyo H, Larson CP, Howard C, Mazhani L, et al. Partnerships for global child health. Pediatrics. 2017;140(4):10.

28. Underwood M, Gleeson J, Konnert C, Wong K, Valerio B. Global host partner perspectives: utilizing a conceptual model to strengthen collaboration with host partners for international nursing student placements. Public Health Nurs. 2016;33(4):351–9. Google Scholar

29. John CC, Ayodo G, Musoke P. Successful Global Health research partnerships: what makes them work? Am J Trop Med Hyg. 2016;94(1):5–7.

30. Birch AP, Tuck J, Malata A, Gagnon AJ. Assessing global partnerships in graduate nursing. Nurse Educ Today. 2013;33(11):1288–94.

31. Herrick C, Brooks A. The binds of global health partnership: working out working together in Sierra Leone. Med Anthropol Q. 2018;32(4):520–38.

32. Njelesani J, Stevens M, Cleaver S, Mwambwa L, Nixon S. International research partnerships in occupational therapy: a Canadian-Zambian case study. Occup Ther Int. 2013;20(2):75–84.

https://reviewofconphil.com

33. Kamya C, Shearer J, Asiimwe G, Carnahan E, Salisbury N, Waiswa P, et al. Evaluating global health partnerships: a case study of a Gavi HPV vaccine application process in Uganda. Int J Heal Policy Manag. 2016;6(6):327–38.

34. Ndenga E, Uwizeye G, Thomson DR, Uwitonze E, Mubiligi J, Hedt-Gauthier BL, et al. Assessing the twinning model in the Rwandan human resources for health program: goal setting, satisfaction and perceived skill transfer. Glob Health. 2016;12(1):4.

35. Sandwell R, Bonser D, Hebert E, Kilroy K, Leshabari S, Mwanga F, et al. Stronger together: midwifery twinning between Tanzania and Canada. Glob Health. 2018;14(1):123.

36. Sriharan A, Harris J, Davis D, Clarke M. Global health partnerships for continuing medical wducation: lessons from successful partnerships. Heal Syst Reform. 2016;2(3):241–53.

37. Yarmoshuk AN, Guantai AN, Mwangu M, Cole DC, Zarowsky C. What makes international global health university partnerships higher-value? An examination of partnership types and activities favoured at four east African universities. Ann Glob Heal. 2018;84(1):139–50.

38. Citrin D, Mehanni S, Acharya B, Wong L, Nirola I, Sherchan R, et al. Power, potential, and pitfalls in global health academic partnerships: review and reflections on an approach in Nepal. Glob Heal Action. 2017;10(1):1367161.

39. Hodson DZ, Etoundi YM, Parikh S, Boum Y. Striving towards true equity in global health: a checklist for bilateral research partnerships. PLOS Global Public Health. 2023 Jan 18;3(1):e0001418.

40. Ramaswamy R, Kallam B, Kopic D, Pujic B, Owen MD. Global health partnerships: building multi-national collaborations to achieve lasting improvements in maternal and neonatal health. Glob Health. 2016;12(1):22.

41. Bruen C, Brugha R, Kageni A, Wafula F. A concept in flux: questioning accountability in the context of global health cooperation. Glob Health. 2014;10(1):73.

42. Thiessen J, Bagoi A, Homer C, Rumsey M. Qualitative evaluation of a public private partnership for reproductive health training in Papua New Guinea. Rural Remote Health. 2018;18(4):10.

43. Storr C, MacLachlan J, Krishna D, Ponnusamy R, Drynan D, Moliner C, et al. Building sustainable fieldwork partnerships between Canada and India: finding common goals through evaluation. WFOT Bull. 2018;74(1):34–43.

44. Besançon S, Sidibé A, Sow DS, Sy O, Ambard J, Yudkin JS, Beran D. The role of non-governmental organizations in strengthening healthcare systems in low-and middle-income countries: Lessons from Santé Diabète in Mali. Global Health Action. 2022 Dec 31;15(1):2061239.

45. Callaghan-Koru JA, Islam M, Khan M, Sowe A, Islam J, Mannan II, George J, Bangladesh Chlorhexidine Scale Up Study Group. Factors that influence the scale up of new interventions in low-income settings: a qualitative case study of the introduction of chlorhexidine cleansing of the umbilical cord in Bangladesh. Health Policy and Planning. 2020 May;35(4):440-51.

46. Leffers J, Mitchell E. Conceptual model for partnership and sustainability in global health. Public Health Nurs. 2011;28(1):91–102.

47. Lipsky AB, Gribble JN, Cahaelen L, Sharma S. Partnerships for policy development: a case study from Uganda's costed implementation plan for family planning. Glob Heal Sci Pract. 2016;4(2):284–99.

48. Perez-Escamilla R. Innovative healthy lifestyles school-based public-private partnerships designed to curb the childhood obesity epidemic globally: Lessons learned from the Mondelez International Foundation. Food Nutr Bull. 2018;39(1_suppl):S3–21.

49. El Bcheraoui C, Palmisano EB, Dansereau E, Schaefer A, Woldeab A, Moradi-Lakeh M, et al. Healthy competition drives success in results-based aid: lessons from the Salud Mesoamerica initiative. PLoS One. 2017;12(10):e0187107

استكشاف الدور الحاسم للممرضات في تعزيز وتحقيق المساواة في مجال الصحة العالمية: التحديات والفرص والاستراتيجيات المستقبلية

الملخص

الخلفية: تلعب الشراكات العالمية للصحة (GHPs) دورًا حاسمًا في معالجة عدم المساواة الصحية وهي ضرورية لتحقيق أهداف التنمية المستدامة. ومع ذلك، تواجه هذه الشراكات غالبًا تحديات تتعلق بالفوارق التاريخية وعدم توازن القوى، وخاصة بين الكيانات في الشمال والجنوب.

الأساليب :ستخدمت هذه الدراسة تحليلًا نقديًا تفسيريًا لتحليل الأدب الذي تمت مراجعته من قبل النظراء والمصدر بين عامي 2010 و2023، مع التركيز على الشراكات العالمية للصحة. تم إجراء مراجعة شاملة منهجية عبر ست قواعد بيانات :Medline، Embase، PsycINFO، CINAHL، Web of Science، وScopus، باستخدام كلمات رئيسية مرتبطة بالصحة العالمية وتقييمات الشراكات. تم تقييم المقالات المختارة بناءً على مدى ملاءمتها لشراكات الشمال والجنوب.

النتائج :كشف التحليل عن تباين كبير في كيفية تقييم الشراكات العالمية للصحة، حيث كان التركيز السائد على الجوانب التشغيلية للشركاء من الجنوب بدلاً من الديناميكيات التوزيعية العادلة. غالبًا ما سلطت الأدبيات الضوء على النوايا النبيلة لشراكات الصحة العالمية مع إغفال الفوارق الهيكلية الأساسية التي لا تزال قائمة. من بين الموضوعات الرئيسية المحددة كانت أهمية مراحل التعاون الأولية، والتحديات المتعلقة بالحكم، وشفافية العمليات، والحاجة إلى توزيع عادل للموارد. من الجدير بالذكر أن المؤلفين المرتبطين بهذه الدراسات كانوا في الغالب من الشمال العالمي، مما قد يؤثر على طريقة تشكيل الديناميكيات الشراكية.

الخاتمة :على الرغم من أن الشراكات العالمية للصحة لديها القدرة على تعزيز الصحة العادلة، فإن فعاليتها غالبًا ما تتأثر بالفجوات المستمرة في السلطة وتوزيع الموارد. من الضروري اتباع نهج أكثر عدلاً لضمان أن تعالج الشراكات العالمية للصحة احتياجات الفئات المحرومة بشكل حقيقي. يجب أن تركز أبحاث المستقبل على التحليلات النقدية للسلطة ودمج وجهات نظر الجنوب في تقييم الشراكات العالمية للصحة.

الكلمات المفتاحية :الشراكات العالمية للصحة، الصحة العادلة، ديناميكيات الشمال والجنوب، عدم توازن السلطة، مراجعة منهجية.