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Dreaming partnership, enabling inequality: administrative infrastructure in global health science

Johanna T. Crane

Prelude

It is May 2014, and I have recently returned to Mbarara, Uganda. I check in to the guest house run by an American university with a sizable research presence at the local medical school. Many of the university's studies in Mbarara are connected to Dr Jason Beale,[1] an American global health researcher who shifted the focus of his HIV treatment research from San Francisco to Uganda beginning in 2002. Since then, the partnership between his university and Mbarara's medical school and HIV clinic has grown into an informal web of internationally funded studies of varying sizes – some run by Ugandan collaborators, some by himself or his mentees, and some by colleagues at other universities – and a staff of over 60 local Ugandan employees.

On my arrival, Beale suggests a Skype call from his US office in order, in his words, to 'provide context to the ever changing political economy of the collaboration'. The internet connection – unreliable even within the enclave of the guest house – holds, and we have a lengthy discussion about the project's uncertain funding future, which then transitions into a conversation about what he describes as 'making the sausage in global health'.

Reflecting on his career, Beale tells me he feels that there is a 'romantic', 'Mountains Beyond Mountains' (Kidder 2003) view of global health: people think global health work is about laying hands on sick people in poor countries, and about saving lives through collaborative intervention. He is not mocking this view: as a physician who began his career caring for low-income HIV patients in New York and San Francisco in the pre-treatment era, Beale understands both the romance and the brutal reality of care in the context of crisis. This is what makes it a morally transformative experience (Wendland 2012). But now, from his desk back in the US, he tells me that this is not what the bulk of global health work is. Instead, he insists, a global health career is largely about sitting at a computer making conference calls – something he estimates he does for ten hours nearly every day. Calls about fiscal management, about safety and security, about negotiating for research space. Conference calls about administration. It is the administrative work that is the 'bread and butter' of global health, he asserts: 'Administration is where the locus of control is.'

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[1]All names are pseudonyms.

Dreams and realities in global health

I worked for Dr Beale as a research assistant in San Francisco beginning in 1999, and later studied his project as an ethnographer when he shifted the focus of his HIV research to Uganda in 2002 (Crane 2013). Over the years, we have had an ongoing dialogue about the power dynamics inherent in global health work. Beale's reflections during our Skype call reveal two important correctives to North American imaginaries of global health. First, much of the work is administrative and logistical rather than clinical or scientific – a reality that does not fit with romantic notions of global health as hands-on, life-saving care. Second, control over collaborations remains a priority, a reality that chafes against the field's self-definition as rooted in 'the mutuality of real partnership' between wealthy and poor countries (Koplan *et al*. 2009). It is this tension between collaboration and control – and how it manifests in the administrative infrastructures of global health partnerships – that is the focus of this article.

'Global health' is a popular term referring to many kinds of activities, ranging from humanitarian aid programmes to international elective courses for medical students (Prince and Marsland 2013). In the United States, university involvement in global health has skyrocketed in the last fifteen years. One study found that the number of global health initiatives on surveyed campuses had tripled every five years (Matheson *et al*. 2014). Reflecting this trend, the Consortium of Universities for Global Health (CUGH) was inaugurated in 2005 and now includes over 180 universities from around the world, the majority located in the United States. This article focuses on academic 'global health science', by which I mean global health research conducted under the auspices of a university-based programme. In the US, global health science is typically funded via federal grants or foundations, overseen by US principal investigators, and carried out in clinics, hospitals or communities in low-income countries, often in Africa. Global health *science* differs from other forms of global health in that its focus is the production of knowledge rather than aid provision or medical education. However, in practice, these different types of global health activities often overlap (for example, university-run global health research may provide scientific evidence to support clinical and humanitarian interventions), and it is not uncommon for a US university to be involved in all of them.[2]

Transnational health research has a long history that predates the current enthusiasm for 'global health'. 'Tropical medicine' – a field born out of European colonialism – investigated infectious diseases such as yellow fever, malaria and yaws. In the 1960s and 1970s, the field of 'international health' worked with international development in Africa and focused on questions of nutrition and maternal and child health (Giles-Vernick and Webb 2013; Thomas 2003; 2017; Vaughan 1991). Although scholarship is divided over

[2]This is especially evident in African countries receiving HIV treatment aid through the US President's Emergency Plan for AIDS Relief (PEPFAR), where US universities sometimes both implement and study PEPFAR-funded antiretroviral treatment programmes. While Dr Beale's university did not play a role in implementing HIV treatment in Uganda, his research programme worked closely with PEPFAR-funded staff in Mbarara, eventually sharing a 'data room' at the HIV clinic, data entry staff and equipment, and a large clinical database used both to evaluate PEPFAR and to collect scientific data about patient outcomes.

whether global health interventions represent a form of continuity with these older forms or a rupture from them (Birn 2009; 2014; Manton 2015; Nguyen 2015; Packard 2016), the shift to 'global' health has undoubtedly come with an unprecedented level of reliance on and faith in quantitative metrics of impact and efficacy (Adams 2016). Moreover, the field of global health claims a fundamental difference from older models of transnational medicine in that it aspires to equitable partnerships between wealthy and poor nations. In a 2009 *Lancet* article, a group of international authors representing the CUGH argued for 'a common definition of global health' emphasizing 'the mutuality of real partnership, a pooling of experience and knowledge, and a two-way flow between developed and developing countries'. 'The developed world,' the authors noted, 'does not have a monopoly on good ideas' (Koplan *et al*. 2009).

In this way, 'partnership' is central to the way in which global health science is imagined, or dreamed, by its leading practitioners. Many African researchers share this vision of good partnerships as rooted if not necessarily in resource equity, then in an equity of ideas and scientific contribution (Parker and Kingori 2016; Okwaro and Geissler 2015; Okeke 2018; Boum 2018). This dream of partnership distinguishes global health from its paternalistic antecedents and stakes an ethical claim – two interrelated goals. Global health depends on inequality for its existence (Crane 2013), and, by embracing partnership, global health programmes and professionals stake out an ethical relationship to this inequality: their intent is not exploitation of poverty for scientific or educational gain, but collaboration to improve health and reduce human suffering. In this dream, 'real partnership' bridges international resource inequalities (although 'partnership' language may in fact mask inequalities and disagreements; see Okwaro and Geissler 2015; Peterson and Folayan 2017). Frequently, 'capacity building' is the mechanism for this bridging and indicative of a non-exploitative partnership. Like global health, capacity building emerged as a way to signal a break with older, more paternalistic modes of engagement between wealthy former colonizing powers and poorer formerly colonized nations (Geissler and Tousignant 2016). To build capacity, global health partnerships provide training and (less often) material support to the lower-income (again, often African) partner (Wendland 2016). As such, the goal of capacity building contributes to an imaginary of global health as an apolitical, humanitarian, and even heroic endeavour (Geissler and Tousignant 2016).

This vision of global health contrasts with the mundane and even boring organizational work that undergirds partnerships and is essential for their continued existence. In practice, global health necessitates a huge amount of administrative coordination and bureaucratic infrastructure. University global health projects vary in size from small studies such as Beale's pilot research to large institutional partnerships that involve millions of dollars and new research and clinical facilities (Mika 2016).[3] Either way, partnerships require negotiation of legal registration in the host country, transnational hiring and firing, supply procurement, and payroll

[3]It is worth noting that even grants considered small by US scientific research standards – say US$50,000 – represent considerable amounts of money to most African public hospitals and universities, where government salaries are often insufficient to support a middle-class existence and postgraduate research is typically self-funded.

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and taxation compliance across multiple national and international bureaucracies and currencies. They require daily conference calls across multiple time zones, and constant attention to cash flow or 'money on the ground'. Despite the reputation of bureaucracies as faceless, this type of work often relies heavily on personal relationships and care (Brown 2015; Van Eijk 2017). This is not the stuff that dreams are made of, but it is the reality of global health science.

This reality, and the challenges it brings, has given birth to global health 'enabling systems' or 'global operations support'.[4] These are administrative structures and practices that facilitate, or enable, institutional partnerships between wealthy and poor nations. Designed by Northern universities, these forms of administrative infrastructure are intended to smooth and monitor the flow of money and other resources to collaborators in poor countries, as well as to insulate Northern universities from legal and financial risk. But their consequences for the dream of equitable partnership are more troubling, as this type of administration can also redirect risk to under-resourced partner institutions, eroding rather than building capacity in the African public sector.

This article uses ethnographic engagement with Dr Beale's partnership and anthropological inquiry into the administrative norms and discourses of US research universities to analyse the administrative infrastructures underpinning global health research partnerships in Africa. Science studies scholars and anthropologists have argued for the importance of studying so-called 'boring things' – standards, bureaucracies, routinization, codes and databases, for example – as a way to bring to the surface the assumptions and power relations that often lie embedded within them (Lampland and Star 2009; Van Eijk 2018). And yet, despite the fact that administration is a crucial element of global health 'experimental infrastructures' (Mika 2016), there has been little examination of 'boring' administrative things in global health science.[5] This article is an effort to address that gap by focusing on fiscal administration as a novel ethnographic object within the anthropology of global health. The first part of the article is a case study of the fiscal administration of Dr Beale's early Ugandan research. The second part describes the institutionalization of some of the administrative norms and practices used by his project within global health enabling systems. The case study allows for a nuanced account of the challenges and relational dynamics of administering global health science on the ground, while the analysis of enabling systems shows how US universities have attempted to codify and standardize some of these practices on an institutional level. I analyse the case study and enabling systems to show how these administrative strategies create parallel infrastructures that avoid direct partnership with African public institutions and may facilitate the outsourcing of legal and financial risks inherent in international partnerships to African collaborators. In this way, these strategies act to *disable* rather than *enable* (or build) African research and institutional capacity, and have profound implications for African institutions as well as for the dream of 'real partnership' in global health. My analysis is based on interviews conducted

[4]See 'Enabling systems', Consortium of Universities for Global Health (CUGH) <https://www.cugh.org/committees/global-health-operations-committee>, accessed 14 November 2019.

[5]The exception to this is some excellent work on data making and practices of enumeration (see, for example, Biruk 2018; Sangaramoorthy and Benton 2012; Mahajan 2008; Adams 2016).

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with Dr Beale, his staff and his collaborators in Uganda, and with American university administrators and faculty engaged in the development of administrative enabling systems, as well as participant observation at CUGH meetings and a review of relevant material available on university and CUGH websites. This fieldwork began with my ethnographic study of Dr Beale's research project in 2004–05 and has continued in a more intermittent fashion since then in the form of follow-up interviews and conference observations.

Administering partnership: a case study

The early years of Dr Beale's research partnership in Uganda offer an instructive example of the administrative challenges that arose as US universities expanded their activities in Africa in the early years of the new millennium. Americans and Ugandans have been involved in collaborative health research since Uganda's independence from Britain in 1962 and the subsequent Africanization of medical research. Some of these projects have taken shape as informal agreements between researchers and clinicians, while others are ongoing formal partnerships between institutions (Mika 2009; 2016). Beale's work began informally as an agreement between himself and the director of Mbarara's HIV clinic, and later evolved into a formal partnership between his US university and the Ugandan medical school where the HIV clinic was housed.

Beale's initial research presence in south-western Uganda was relatively small. In 2002, he forged a fledgling partnership with the HIV clinic I call the Immune Wellness Centre, where he launched a pilot study of patient adherence to antiretrovirals. The study was funded by a small National Institutes of Health (NIH) grant and necessitated only a handful of employees. Dr Beale travelled to Uganda multiple times a year, but the daily labour of running the study was carried out by his project manager who relocated to Mbarara from her home in California.

The medical school housing the Immune Wellness Centre did not have a contracts and grants office to administer Beale's research grant. It was a young university, only twenty-five years old at the time, and, like many African universities, its primary focus was teaching and not research. As a result, during the earliest phase of Beale's project, the study managed its operations via a US$8,000 petty cash account based in the US that the project manager could access using her ATM card when she needed to pay staff or cover operating expenses. However, at the time the study began, ATMs were a new phenomenon in Uganda and there were no machines outside the capital city. Administering funds in this way required that the project manager make weekly four-and-a-half-hour trips to Kampala in order to withdraw the cash she needed to keep the study running.

The study's expenses eventually outgrew the petty cash account as the research moved beyond the pilot phase and acquired a larger staff. The project shifted to pay employees as independent contractors via Beale's university. This method also proved problematic. Employees submitted invoices for their hours to the university's accounting department to be processed along with the thousands of others that came in each month. Each employee payment had to be wired to Uganda, incurring US$30 fees on amounts that were often only US$150 in total. The process took several months, delaying the salaries of Ugandan employees. The project manager found herself acting 'like a money-lending agency' to

help staff make ends meet while they waited for paycheques to arrive. Moreover, as independent contractors, staff weren't able to get employee benefits and were responsible for paying their own taxes, a very uncommon and unfamiliar practice in Uganda where taxes are usually deducted automatically.

When the Uganda Revenue Authority inquired why employees were not registered with the tax board, the project again revamped its fiscal administration and founded a non-governmental organization (NGO) to be its fiscal agent. As I describe later in this article, the establishment of a 'shell' NGO or non-profit corporation to act on behalf of a US university would eventually be codified into a standard practice advocated by proponents of global health enabling systems. The American team asked their principal Ugandan collaborator, Dr Iris Akiki, to head the NGO, which I call the Institute for Health Research in Uganda (IHRU). (Due to regulations regarding conflict of interest, no one directly employed by the US university was permitted to be a legal partner or member of IHRU.) Akiki agreed, seeing the task as a favour to her collaborator friends. She had always wanted to start an NGO to 'do broader work', and this seemed like a good opportunity. It also seemed relatively easy, as the research study was still small and the NGO could be run out of the study's existing office. She did not foresee the administrative burden that it would eventually entail.

The indirect costs of partnership

Initially, IHRU functioned well in its capacity as the fiscal agent for the collaboration. Its responsibilities were limited to managing Dr Beale's study of antiretroviral adherence, which was then supported by a large NIH grant with an annual budget of over US$1 million. IHRU received a percentage of this NIH grant to cover its operating expenses – or what, in the language of grants administration, are called 'indirect costs'. Often referred to as 'overhead' or 'facilities and administration' costs, indirect costs are funds paid to grant recipients in order to reimburse for institutional expenses not directly attributable to any single research study, such as heat, electricity or human resources administration. Indirect costs are reimbursed as a percentage of the grant received, and, in the US – where universities negotiate this percentage with federal grant agencies – reimbursement rates often run at over 50 per cent, meaning that for every dollar received for direct research costs, the principal investigator's home institution will receive 50 cents to cover indirect expenses (Brainard 2005). By contrast, NIH rules restrict foreign institutions to an indirect cost reimbursement rate of 8 per cent.[6] During the initial years of the collaboration, Dr Beale was employed by a public university with a negotiated indirect cost rate close to 50 per cent. Later, he moved to a large private university with a negotiated rate of nearly 70 per cent.[7] But IHRU, as a foreign entity, was restricted to the 8 per cent rate.

[6]This figure represents an increase from the 0 per cent rate of the 1980s, a product of Reagan-era sentiments towards foreign 'aid'. The rule changed in the 1990s, when fears about 'emerging diseases' made the climate for international health funding more favourable and NIH officials successfully lobbied for an increase to 8 per cent, the same amount offered to recipients of NIH training grants (John McGowan and Gray Handley, NIH, personal communication).

[7]For a variety of reasons, these negotiated rates can be somewhat higher than what universities actually receive (Ledford 2014).

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The 8 per cent reimbursement rate was initially sufficient for IHRU to cover the costs of administering the finances, space and human resources for Dr Beale's flagship study. However, the organization began to struggle once the international research presence at the clinic expanded. Dr Beale's success in Mbarara drew other foreign researchers to the site. IHRU became responsible for administering not only the original study, but a larger and more complex web of research projects encompassing many other smaller studies overseen by Dr Beale's colleagues. By 2009, the collaboration included HIV-related studies concerning alcohol use, food insecurity, prevention education, lipoatrophy, transportation, mortality, dermatology and paediatric medication adherence. The growth in projects gave IHRU the appearance of being flush with international research money. But in reality these new studies had much smaller budgets than the original project (some had no funding at all), meaning that the 8 per cent indirect cost reimbursement didn't yield much revenue. As the project manager observed, 'Eight per cent of $5,000 is less than $500. However, whether it's a small grant or a big grant, you still have to hire staff, pay them, do accounting. You account for $5,000 the same way you account for $50,000.'

Administrative nightmares

In practice, the dreams of heroic global health science and collaborative partnership chafe against the administrative nightmare of coordinating across multiple national, state and institutional bureaucracies. Although bureaucratic requirements for research administration have increased within the global North as well, the administrative burdens associated with international partnerships are in many ways greater than for US-based research. For IHRU, simple things – such as renting research space – became significant challenges. In Uganda, rent is typically paid months or even a year in advance in a large lump sum, rather than on a monthly basis as in the US. Institutional regulations would not allow Beale's university to advance IHRU the cash for months of rent; they were permitted only to reimburse for rent already paid. At one point, IHRU spent a large sum to rent space for a Centers for Disease Control and Prevention project that never materialized. Variability in international currency exchange rates further complicated project accounting. IHRU budgeted in dollars only to find that they could not cover expenses when the value of the dollar dropped. Employees carefully followed the exchange rate – broadcast nightly on the news – in an effort to keep track of their constantly fluctuating salaries. Moreover, because the Ugandan government calculated taxes on a different day from the one on which employees were paid, staff were paid and taxed at different exchange rates. IHRU was responsible for tracking both. In short, as the international research presence grew, IHRU was faced with increased administrative responsibilities but little additional funding to support this work. Eventually, the organization began running at a deficit.

Budgetary constraints also had an impact on the composition of IHRU's board of directors in ways that caused tensions in the partnership. Akiki included some members of her family on IHRU's board. Beale and his project director objected, fearing that it would read as corrupt to US funding agencies. Akiki stood her ground, pointing out that board membership in Uganda was different from that in the US in that members expected to be paid. IHRU, with its limited 8 per cent in indirect cost reimbursement, could not afford to pay a board. Akiki had chosen the only people who would do it for free and whom she could trust: her

family. Outsiders, she feared, would seek to benefit financially from IHRU, or possibly to take it over.

Study staff were also unhappy with the administrative situation. Staff did not consider themselves as working for IHRU, even though that is how they appeared on official tax documents. Listing themselves as employed by a prestigious US university was a valuable entry on their résumés; being on the staff of an unknown NGO called IHRU was not. Employment with universities such as Harvard, UCSF (University of California, San Francisco) or Johns Hopkins may feed the cosmopolitan dreaming of some African field staff by connecting them to Western metropoles (Biruk 2012; 2018). Moreover, staff did not report to IHRU but to the individual scientists heading their studies, who were also the ones who set their work requirements and benefits. When the American principal investigator of one well-funded study offered her employees additional insurance for their spouses and families, employees of a different study demanded that they get the same by arguing, 'We are all IHRU employees.' Dr Akiki was stuck in the middle, trying to explain the differences between an R21 and an R01 NIH grant and why one study could afford to provide extra insurance while another one could not. Both she and the employees were confused about the extent of her authority and whether or not those paid through IHRU were, in fact, her staff.

Things came to a head in 2009 when IHRU underwent an audit in preparation for the organization's five-year renewal by the Ugandan government. The audit highlighted some major concerns regarding cash flow and breaches of Ugandan labour laws. These problems stemmed from the collaboration's growth and structure. As the collaboration expanded, each new study joined IHRU with a different budget for similar categories of staff. This, in combination with the exchange rate variability, meant that IHRU records showed several different salaries for each employee. Furthermore, many employees were inherited from the collaboration's earlier days and there were no records documenting that they had been hired in accordance with Ugandan labour regulations. Dr Akiki feared that the organization would not be renewed, and, more seriously, that she might be found in violation of the law.

In light of these concerns, Dr Akiki and the board moved to restructure IHRU. This was done independently, without consulting the American team. All staff reapplied for their positions to ensure proper documentation. Mid-level managers were hired to oversee employees, interrupting the personal relationships between staff and principal investigators, who were accustomed to communicating directly. All employees would be both paid and taxed at a single exchange rate, determined by averaging exchange rates for the previous year (2008). Unfortunately, the new averaged rate was lower than the current rate, meaning that staff would be getting less money. This caused a great deal of resentment among IHRU's employees, some of whom accused Akiki of 'eating' (stealing) their salaries. (In fact, Akiki received very little pay for directing IHRU, and initially undertook the work for free.) In response to the conflict, Dr Beale made an emergency visit to Uganda to hold a resolution meeting.

In the end, IHRU passed its renewal, but Beale decided to transition away from using the NGO as his fiscal agent and towards a more direct partnership with Mbarara's medical school. The chaos and staff disgruntlement that erupted with IHRU's sudden restructuring convinced Beale and the medical school (which feared losing its most valuable international partner) to establish a

university contracts and grants office to manage externally funded research. Its founding required considerable research and advocacy by the Ugandan university dean, who became its first director, as well as by Beale and his project manager. The costs of establishing the office were underwritten by an NIH grant specifically aimed at building institutional capacity, as well as by significant, unbudgeted expenditures provided by Beale's university. Founded in December 2009, it was the first central grants office at any Ugandan public university, and became the exclusive administrator of Beale's grants from that point onwards. Akiki and Beale ceased collaborating, although they remained cordial, and both agree that IHRU's structure and US low indirect cost reimbursement rates set the organization up for failure. Akiki went on to pursue her PhD and continues to receive small grants for health intervention projects – such as bed net distribution – through IHRU.

The story of IHRU reflects some important themes in the development of academic global health partnerships. Established just prior to the recent rise of 'global operations' offices at US universities, IHRU's trajectory demonstrates a real need for the more coordinated approach to transnational administration that the 'enabling systems' approach described below offers. Some challenges experienced by IHRU are precisely the type of issue that enabling systems are designed to handle smoothly. Yet IHRU's story raises concerns about the consequences of running a partnership through a proxy NGO or non-profit corporation – an increasingly common enabling systems practice. Establishing IHRU allowed Beale to shift some of the fiscal and legal risks of transnational partnership to IHRU, as it was Akiki, and not Beale or his university, who was ultimately liable for any violations of Ugandan law or US federal accounting regulations. Moreover, IHRU allowed Beale's university to avoid direct fiscal and administrative partnership with Akiki's university, a move typical of enabling systems that should be understood within the long history of Western non-investment in Africa's public sectors. Below, I outline the concept and structure of global health enabling systems in greater detail, and describe how these structures may have an impact on institutional capacity in Africa.

Enabling systems

Historically, Uganda's international research partnerships have occurred primarily via Makerere University in Kampala and its teaching hospital, Mulago. From Idi Amin's rule in the 1970s to the current government under Yoweri Museveni, Uganda's universities have suffered from chronic underfunding by the state, and foreign partnerships have been the best means of securing scientific research funding (Iliffe 2002). Some partnerships have taken shape as informal agreements between researchers and clinicians, as Beale's did initially, while others are ongoing formal collaborations between institutions, as Beale's project later became. But the reliance on proxy fiscal administrators such as IHRU – enabling systems – is a new phenomenon and reflects the involvement of US university administrators in global partnerships at a level not seen during the colonial or early postcolonial eras. This shift, I argue, is linked to the exponential increase in global health projects within US universities during the first decades of the new millennium, and the significant legal and financial risks posed by international work on this scale.

The concept of global health enabling systems – university fiscal, legal and administrative arrangements designed to facilitate and smooth partnerships and collaborations with foreign entities – is promoted by the CUGH, which was founded in San Francisco in 2008. The notion grew out of an administrative initiative at the University of Washington (UW) called the Global Support Project, which was launched in 2006 by the university's Finance Office in response to increasing requests for cash abroad, primarily from faculty working in parts of Africa. The project later became institutionalized as the university's office of Global Operations Support. UW was one of the founding members of the CUGH, and, until recently, its faculty and staff led the organization's enabling systems committee (recently renamed the Global Health Operations Committee).[8] UW's global operations support system has been used as a model by other universities, including Duke and Harvard, in designing their administrative platforms for international work. For these reasons, much of my description of enabling systems will focus on UW's approach, as the processes and procedures pioneered by UW serve as a template for the enabling systems approach to global health administration.

The strategy of establishing a 'shell' non-profit such as IHRU to work on behalf of a US university has been promoted at CUGH meetings and by the UW's Global Operations Support office as a means by which research programmes may legally register, open a bank account and hire staff directly in-country. Many African nations do not have a mechanism for foreign universities (especially public universities run by US state governments) to register as legal entities and open bank accounts, contributing to the cash flow challenges described in the case study. At UW, as global health activities ramped up in the 1990s and 2000s, faculty would travel to field sites with large amounts of cash (US$80,000 in a suitcase to Albania, in an example one administrator gave me) and deposit the grant money into a personal bank account where it could then be used to pay for research space, supplies and employees. Uncomfortable with the informality and lack of university oversight of this practice, in 2008 UW's fledgling global support initiative recommended that the university establish a non-profit corporation, dubbed 'UWorld', that could legally register (and thus open bank accounts) in host countries – much as IHRU had done for Beale's project. This approach was embraced by the CUGH and promoted at its inaugural meeting in 2008, where a UW administrator described it as a way to be 'creative and compliant at the same time'. Although US university administrators see these non-profits as practical rather than political entities, such bodies do have an impact on global health governance. Their existence and practices raise important questions about the ability and responsibility of funders, partner institutions and African states to organize

[8]On its website, the CUGH describes the Global Health Operations Committee's work as 'set[ting] up guiding principles to include university administrations' procedural and financial alignment with programmatic priorities in global health' and 'develop[ing] strategies to effectively respond to global opportunities and share best practices for accepting and managing international risk, financial services, academic human resources, legal frameworks, communication and outreach, information technologies, transparency in approach and efficiencies with international sites' (<https://www.cugh.org/committees/global-health-operations-committee>, accessed 12 October 2019).

and deliver the resources that partnerships bring – what Hannah Brown calls a 'politics of sovereign responsibility' (Brown 2015).

In the years since the founding of the CUGH, the use of a proxy non-profit has been codified in the UW's *International Projects Start-Up Guide*, a 105-page document produced by the Global Operations Support office and intended to assist faculty, staff and students involved in planning and implementing projects located in foreign countries.[9] Other universities offer similar options: Harvard University, for example, established Harvard Global Research and Support Services Inc. ('Harvard Global') in 2012 as 'an affiliated and separate nonprofit legal entity that manages overseas administrative services' for Harvard projects abroad.[10] The guide offers a nuts-and-bolts approach to the legal and fiscal intricacies of establishing an international project. Notably, this document contains none of the heroic imaginary that so often surrounds global health work. Nor does it speak to the dreams of equitable partnership espoused by the field's leaders. The dream here is one of coordination and compliance. 'Partnership' is mentioned only as a formal, legal agreement between institutions, and not as an affective relationship or ethical commitment (Taylor 2018).

The UW *International Projects Start-Up Guide* includes a list of the advantages and disadvantages of administering a global health project through an affiliate non-profit.[11] In comparing this list to the story of IHRU – which, although not a UW programme, did use a version of this administrative structure – a number of noteworthy points emerge.[12] In somewhat confusing language (the non-profit is called the 'UW registered program' even though it is legally and fiscally distinct from the university), the guide's list of disadvantages accurately describes two of the principal challenges faced by IHRU: complying with transnational labour and tax laws; and the legal and fiscal liability incurred by non-compliance. In IHRU's case, the difficulty of documenting and justifying the project's hiring and salary practices (and the threat of liability for failure to do so) threatened the viability of the organization and led to its sudden restructuring by Dr Akiki, who was ultimately liable for any legal breaches. The 'shell' non-profit structure essentially

[9]See <http://finance.uw.edu/globalsupport/home>, accessed 12 October 2019.

[10]See <https://www.globalsupport.harvard.edu/about> and <https://www.harvardglobal.org/about-us>, both accessed 12 October 2019.

[11]See <http://finance.uw.edu/globalsupport/home>, accessed 5 June 2017:

> Advantages of this option: UW registered program has total control of the hiring process and timeline; Foreign national/UW employee helps bond the foreign-based program with the UW; Hiring local citizens may advance program goals such as building a sustainable administrative infrastructure in the host country.
> Disadvantages of this option: If the UW program is not in compliance with host country employment and tax laws, it may be subject to fines and penalties; It can be complicated to correctly administer a human resources program and to remit the right amount of deductions in a foreign country; Cost of host country legal counsel must be factored into budget.

[12]Unlike IHRU, UWorld is a large parent organization with subsidiaries in different countries (e.g. UWorld Kenya, UWorld Ethiopia, UWorld Botswana) where UW has international projects. In addition, UW has established other non-profit entities that are not part of the UWorld organization, including UW Kenya and I-TECH Kenya.

shielded Beale's university from liability, even though its chief purpose was to administer his research.[13] In this way, the administrative design of the partnership undermined the dream of equitable collaboration held by both Beale and Akiki. Similarly, if a UW international project run through UWorld were to fall out of compliance with local law, UWorld – not UW – could be subject to fines and penalties imposed by the host country. Although UWorld is more tightly tethered to UW than IHRU was to Beale's university – in addition to its referential name, it is also subject to oversight by Washington state auditors – it is nonetheless a separate legal and fiscal entity that has no US offices or employees; nor does it have any employees within the University of Washington. As such, it too serves to buffer the university from the fiscal and legal risks inherent in transnational work.

UW's start-up guide also lists a number of advantages of administering international projects through an affiliate non-profit. These include 'bonding' the foreign programme with the UW through the hiring of foreign nationals and the opportunity to build 'a sustainable administrative infrastructure in the host country' by hiring local citizens. Again, comparing this list with IHRU's case is revealing, and demonstrates the importance of understanding the exact nature of the connection between the US university and its legally registered entity. Legal registration certainly makes it easier for US research projects to hire and pay foreign nationals – indeed, it was one of the primary motivators behind Beale's move to this model. But the UW guide's claim that this 'helps bond the foreign-based program' with the US partner university seems speculative. In the case of Beale's research, Ugandan staff valued the prestige of working for a US university and resented employment by an unknown NGO, which did not look as favourable on their résumés or carry the same cosmopolitan prestige. The inclusion of 'bonding' as an advantage in the UW guide is significant in that it signals the affective aspects of partnerships (friendship, trust, care) that play a huge role in their success or failure but are rarely mentioned in administrative guidance.

Lastly, and most importantly for my argument here, the IHRU example does not demonstrate the UW guide's claim that hiring local employees via a proxy non-profit contributes to 'building a sustainable administrative infrastructure in

[13]The fact that the legal intricacies of partnership can effectively outsource liability is perhaps most dramatically evident in the case of the 'KEMRI Six'. Formed in the early 1980s by the Kenyan government, KEMRI (Kenya Medical Research Institute) is a national agency that has become one of the leading health research bodies on the African continent and hosts extensive collaborations with international partners. According to Denielle Elliott (personal correspondence), in this legal case, six Kenyan scientists seeking to sue the KEMRI–Wellcome Trust Research Programme in Kilifi for racial discrimination found that they were unable to name Wellcome Trust or any of the other British partners (Oxford University, London School of Hygiene and Tropical Medicine and Open University) in the case because none of these institutions were legal entities in Kenya. As a result, KEMRI (the African 'partner'), the Attorney General and the Ministry of Public Health were named in the suit, and they were ultimately the party liable for paying the 30 million Kenyan shillings awarded to the scientists when the court ruled that the partnership's funding qualifications favoured scientists with connections to Europe (Kakah 2014; Nordling 2014; Elliott 2017). The Wellcome Trust and its collaborators did not use a proxy non-profit in this particular case. In Kenya, each research site is governed by a unique agreement that covers issues of intellectual property rights, patents, labour disputes and transnational research. But, despite this, this case powerfully demonstrates the importance of 'boring things', such as legal registration, in shaping power and accountability in global health partnerships.

the host country'. Instead, it appeared to do precisely the opposite, as IHRU eventually crumbled under the dual burden of chronic underfunding and administrative overload. This is not necessarily the case for larger non-profits such as UWorld or Harvard Global, which appear to have greater stability and institutional support than IHRU did. Larger entities such as these may in fact provide administrative infrastructure that endures, as UWorld has done for over a decade at the time of writing. However, the 'sustainability' of these systems comes at the cost of their ownership and control. Indeed, since the founding of the CUGH, African global health leaders have raised concerns about this practice and its impact on African universities. At the organization's first meeting, Nelson Sewankambo, principal of the Makerere University School of Health Sciences in Uganda and CUGH board member, argued that NGOs established by Northern universities were 'undermining local capacity' by setting up separate administrative bodies. He specifically named the University of Washington's non-profit in Addis Ababa, Ethiopia, and urged the UW to instead help the University of Addis Ababa develop the capacity to manage the collaboration's finances. Tom Quinn of Johns Hopkins University, one of Sewankambo's long-time collaborators, echoed this statement, adding that international programmes tended to build independent structures because local ones were 'too difficult'.

The CUGH rightly categorized these proxy non-profits as enabling systems as they are what enable these partnerships to exist and persist. The examples I have given here also show that they may enable certain inequalities as well. On the ground, such systems may raise sentiments of 'managerial disenfranchisement' among African partners (Brown 2015). In reflecting on her experience with IHRU, Akiki noted that the burden of administering Beale's research projects made her unable to think scientifically or apply for her own grants during that time period – turning a project that she had hoped would advance her research career into one that hindered her ability to conduct science. The dual capacity-building and capacity-eroding possibilities of enabling systems are reflected in the multiple dictionary definitions of the verb 'enable', which can mean 'to provide with the means or opportunity'; 'to make possible, practical, or easy'; or 'to give legal power, capacity, or sanction to'.[14] Enabling systems are one way to provide the means or opportunity for partnership – they are intended to make partnership possible and practical. However, they do so by allocating legal power and capacity to non-profit corporations that act primarily on behalf of the US partner institution, while simultaneously shielding them from liability. Might these administrative enabling systems be facilitating arrangements that are harmful to African institution building, even as they make the logistics of partnership easier (Okeke 2018)? In this way, such systems may reflect an alternative definition common in certain subfields of psychology, where 'enabling' refers to the facilitation of self-destructive behaviour by another.[15]

Infrastructural violence

One lens through which to understand enabling systems is to see them as a form of infrastructure, a topic that has garnered significant interest among anthropologists

[14]See <https://www.merriam-webster.com/dictionary/enable>, accessed 1 June 2017.
[15]*Ibid.*

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and science studies scholars in recent years. While much of this literature focuses on infrastructure in the material sense – roads, pipelines, buildings, machines – other work has gone beyond this to analyse people (Simone 2004) and even nature as infrastructural (Carse 2014). The administrative infrastructure I have described has both material and social components. It includes technical artefacts such as paperwork, computers and the internet, but also human knowledge and skills such as accounting, grants management and regulatory understanding (Bowker and Star 1999; Whyte 2011; Van Eijk 2017). Larkin has described infrastructures as 'the architecture for circulation', a definition that is well suited to understanding enabling systems, which are designed precisely to facilitate and manage the circulation of research funds, products and personnel internationally (2013: 328).

In addition to facilitating circulation, enabling systems serve another core purpose: risk management. The recent explosion in global health work has created new risks for US universities. Risk management is one of the hallmarks of infrastructure, but as Howe *et al.* (2015) point out, infrastructures also paradoxically generate new risks. Often infrastructures that benefit some are harmful to others (*ibid.*). At their heart, enabling systems are an infrastructural means of managing the transnational entanglement that global health work necessitates.

Appel's ethnography of offshore oil drilling in Equatorial Guinea makes a compelling argument for the power of infrastructure to disentangle Houston-based companies and employees from the everyday realities of living and working in Central Africa (2012a). By creating standardized, 'modular' administrative, fiscal and legal infrastructures, oil companies allow offshore drilling work to function 'just like' offshore work elsewhere, thus 'disentangling' workers from the social and economic conditions in Equatorial Guinea, as well as any responsibility for them – a phenomenon Appel frames as 'infrastructural violence' (2012b; Rodgers and O'Neill 2012). In global health, by contrast, a certain level of entanglement is both necessary and desirable. US researchers and students seeking a global health experience do not wish to be fully separated from local conditions; rather, the 'dream' of global health requires some degree of immersion in this context. The dream of partnership also requires some form of entanglement, as it privileges a collaborative connection between wealthy and poor countries. At the same time, intellectual and scientific entanglement is not the same as institutional, administrative and fiscal entanglement, and it is the latter that enabling systems are designed to manage. Partnership, it seems, does not extend to the administrative realm.

Why not? One could argue that universities in low-income countries such as Uganda often lack the administrative infrastructures, such as contracts and grants offices, to partner directly with their US collaborators. This is true, although it could also be argued that in the spirit of capacity building, partners should help establish such offices at their host institutions, as Dr Beale eventually did. Alternatively, it is possible that researchers and administrators view and use the idea of 'partnership' differently. For leading global health researchers, partnership means equitable collaboration between wealthy and low-income nations. But when I asked UW's leading global operations administrator to describe projects exemplary of 'partnership', she looked puzzled and asked for clarification – did I mean foreign subcontracts? For her, partnership was a legal term, not an ethical or affective relationship. It is this conceptual fluidity that in part allows

the 'partnership' concept to do different work for different people, and in so doing simultaneously facilitate and undermine the dream of equitable transnational collaboration (Taylor 2018).

In addition, there is another factor at work here: the administrative 'nightmare' of corruption. US scientists and administrators commonly view African public institutions as administratively 'difficult' to work with. Corruption and the mismanagement of funds are prevalent fears, a view that is not unwarranted. In many African countries, including Uganda, local scientists and staff share this mistrust of their national government and public institutions.[16] East African researchers, as well as their foreign colleagues, may understandably prefer to avoid entrenched bureaucracies and work through more nimble structures such as NGOs and proxy non-profits. Such experiences and perceptions then serve to justify the use of enabling systems, which, like IHRU, detour around direct partnership with African institutions and instead establish a parallel administrative system that is more directly answerable to the US partner. The difficulties of working through entrenched and sometimes corrupt African bureaucracies are real. However, what gets lost in this picture – but what the case of IHRU clearly shows – is the fact that many of the administrative difficulties associated with global health are not specifically *African* but rather are *transnational* problems (McKay 2012; Conteh and Kingori 2010). Akiki's struggle to reconcile currencies, the lack of proper hiring documentation, IHRU's controversial board membership and the organization's fiscal precarity – all of these emerged from the transnational challenge of aligning systems and rules across countries and continents. They were American problems as much as Ugandan ones, although the burden was not shared equally.

Conclusion

The use of 'enabling systems' to circumvent African institutions is a new example of a long-standing problem. For the last generation, US policies and programmes have worked to de-capacitate the African public sector, first by supporting structural adjustment programmes and more recently by promoting NGOs and other parastatal bodies as the primary partners for US projects and grants (Pfeiffer and Chapman 2010; Prince and Marsland 2013; Geissler 2015). Ironically, as Geissler and Tousignant point out, the rise of 'capacity building' as a goal of international aid coincided with the erosion of the public sector in recently independent African nations, often via economic programmes promoted by donor nations (2016; Barnhart and Diallo 2016). The ongoing consequences of this hollowing out were recently made dramatically evident by the West African Ebola outbreak, which was spread and amplified by the lack of adequate public health infrastructure and staffing (Packard 2016). Moreover, the underfunding of health systems in

[16]It is worth noting that there is also a common perception among many people in African countries that American and other foreign entities are corrupt in that they essentially enrich themselves with money intended to support African health and development. These suspicions, in part, reflect the vast differences in pay, housing and benefits between foreign and African national staff, and the significant amount of 'global health' money that ultimately benefits American/foreign institutions and economies (Barnhart and Diallo 2016).

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Africa and elsewhere is responsible for a tremendous amount of less spectacular but no less tragic sickness and mortality that rarely makes international news (Livingston 2012; Mika 2016; Street 2014). Global health science plays a role in this, as internationally funded research projects contribute to the 'internal brain drain' of poorly paid public-sector clinicians into research work while providing patient participants forms of treatment and monitoring typically unavailable via the underfunded public health system (Pfeiffer *et al*. 2014; Meinert and Whyte 2014; Petryna 2009). The need for public-sector strengthening in Africa remains imperative for both African and global health (Pfeiffer *et al*. 2008; Pfeiffer and Chapman 2015). Why, then, do global health 'partnerships' so often result in the opposite?

The answer may have something to do with how past efforts at partnership are remembered. Graboyes and Carr argue for the importance of institutional memory in shaping future endeavours in global health science (2016). If the failure of a partnership is remembered as resulting from 'African' problems, then future partnerships will likely act on this memory by avoiding direct engagement with African institutions perceived as unreliable or corrupt. This is the logic that sustains the notion and structure of enabling systems. But if the failure of a partnership is remembered as stemming from transnational problems, the role of both 'donor' and 'host' nations and their respective institutions are implicated. This, in turn, might allow us to dream up systems that foster engagement between institutions, rather than enabling partnerships that maintain Northern control.

Institutional memory about how and why some partnerships succeed is equally important. Carpenter's ethnography of the early years of Botswana's HIV treatment programme is instructive here. Carpenter describes how international portrayals of this public–private partnership emphasized the role played by foreign scientific and business expertise, and assumed that Batswana government bureaucrats were an impediment to innovation rather than a productive force helping the partnership succeed (Carpenter 2010). In the prevailing discourse about the programme, 'barriers are called bureaucracy, and success is called partnership'. The institutional memory of this project attributed its success to private philanthropy and industry involvement, and not to public-sector facilitation. Yet Carpenter's research demonstrates that Batswana bureaucrats played a crucial role in enabling the programme to succeed, both on an organizational and an interpersonal level. How partnerships are remembered is not only about the past, but also about our dreams of the future, as institutional memory shapes knowledge and practice about how to build a successful collaboration (Graboyes and Carr 2016).

Although the contexts of Botswana and Uganda are quite different, Carpenter's insights are useful for thinking through the story presented here. Anthropology needs to take a closer and more nuanced look at administration and bureaucracy in global health. Administration and bureaucracy should not be viewed only as forms of biopolitical control or 'audit' culture (Strathern 2000; Graeber 2015); they should be understood as necessary infrastructures and capacities. While the Ugandan state is a deeply troubling 'partner' in ways that Botswana is not, it is capable of making productive investments in healthcare, as Mika's account of recent developments in oncology shows (2016). Moreover, the reliability of the United States as a partner government should not go unchallenged – a point demonstrated by the American military's role in shaping Liberia's

paramilitary response to Ebola (Hoffman 2017). Indeed, in an era when the US executive branch has vowed to dismantle the country's 'administrative state', American global health stakeholders should be wary of our readiness to dismiss state bureaucracies as 'too difficult'. This may come back to haunt us.

As I described earlier, following IHRU's sudden restructuring, Dr Beale, his project manager and Mbarara university administrators worked very hard to establish a contracts and grants office within Mbarara's university – the first such central grants office within any Ugandan public university. The fact that even Makerere (a much older, larger and more prestigious university with pre-existing partnerships) had never established a central grants office testifies to the failure of research partnerships to build African administrative capacity. In establishing a grants office, Beale's collaboration worked to build administrative capacity within an existing state institution. As of 2014, the office was administering over thirty different grant contracts for foreign research collaborators, including all of Beale's grants. Beale described the shift to me as an effort to 'embrace the messiness' of global health collaboration rather than simply try to 'bulldoze' it. Using Carpenter's language, it is perhaps an attempt to move away from the tendency to see bureaucracy as a barrier, and to instead embrace bureaucracy and administrative infrastructure as part and parcel of a successful partnership. Importantly, Beale's project did not interpret the failure of the partnership with IHRU as resulting from 'African' problems. Rather, the partnership's problems were remembered as resulting from transnational issues, many stemming from the US cap on indirect cost reimbursements. I do not mean to portray the new grants office as a perfect partnership – the collaboration continues to have its discontents and inequalities, and the nascent office remains limited by the 8 per cent indirect cost rate, just as IHRU was. But if, as Dr Beale asserted, 'administration is where the locus of control is', then this office is perhaps a step in the right direction.

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Abstract

This article examines the fiscal and administrative infrastructures underpinning global health research partnerships between the US and Uganda, and the power dynamics they entail. Science studies scholars and anthropologists have argued for the importance of studying so-called 'boring things' – standards, bureaucracies, routinization, codes and databases, for example – as a way to bring to the surface the assumptions and power relations that often lie embedded within them. This article focuses on fiscal administration as an understudied ethnographic object within the anthropology of global health. The first part of the article is a case study of the fiscal administration of a US–Uganda research partnership. The second part describes the institutionalization of some of the administrative norms and practices used by this partnership within the 'global health enabling systems' employed by US universities working in Uganda and elsewhere in Africa. I analyse a case study and 'enabling systems' to show how these administrative strategies create parallel infrastructures that avoid direct partnership with Ugandan public institutions and may facilitate the outsourcing of legal and financial risks inherent in international partnerships to Ugandan collaborators. In this way, these strategies act to *disable* rather than *enable* (or build) Ugandan research and institutional capacity, and have profound implications for African institutions as well as for the dream of 'real partnership' in global health.

Résumé

Cet article examine les infrastructures fiscales et administratives qui sous-tendent des partenariats de recherche en santé mondiale entre les États-Unis et l'Ouganda, et les dynamiques de pouvoir qu'elles impliquent. Des chercheurs en sciences et des anthropologues ont plaidé pour l'importance d'étudier les prétendus « aspects ennuyeux » (normes, bureaucraties, routinisation, codes et bases de données par exemple) comme un moyen de faire émerger les hypothèses et les relations de pouvoir qu'ils renferment souvent. Cet article s'intéresse à l'administration fiscale en tant qu'objet ethnographique négligé dans les études anthropologiques de la santé mondiale. La première partie de l'article est une étude de cas de l'administration fiscale d'un partenariat de recherche américano-ougandais. La seconde partie décrit l'institutionnalisation de certaines normes et pratiques administratives utilisées par ce partenariat dans le cadre des « systèmes habilitants de santé mondiale » employés par des universités américaines travaillant en Ouganda et ailleurs en Afrique. L'auteur analyse une étude de cas et les « systèmes habilitants » pour montrer comment ces stratégies administratives créent des infrastructures parallèles qui évitent un partenariat direct avec les institutions publiques ougandaises et peuvent faciliter l'externalisation des risques juridiques et financiers inhérents aux partenariats internationaux vers des collaborateurs ougandais. De cette manière, ces stratégies ont pour effet d'*inhiber* plutôt que d'*habiliter* (ou de renforcer) la capacité institutionnelle et de recherche ougandaise, et ont des implications profondes pour les institutions africaines ainsi que pour le rêve de « vrai partenariat » en santé mondiale.