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Outsourcing sovereignty: global health partnerships and the state in Zambia

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ABSTRACT

Global health organisations are increasingly involved in large-scale health interventions in countries in the Global South, partnering with states to implement programmes to strengthen national health systems and promote Universal Health Coverage (UHC). Drawing on an ethnography of a large-scale global health partnership between the Zambian state and the Clinton Foundation, this paper examines the novel configurations of sovereignty that are created by these large-scale global health partnerships. It shows how officials from the Clinton Foundation came to believe that senior Zambian government actors had granted them the authority to implement the programme outside of the formal channels of the government health system. I conceptualise this as an informal mode of 'outsourcing sovereignty' and show how it led Clinton Foundation employees to behave as de facto state actors in rural Zambia. This paper contributes to the broader critical task of describing and analysing new forms of governmental pluralism in contemporary global health and highlights some of the politically troubling consequences when sovereignty is informally outsourced in this way.

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Within the past decade, many global health organisations have begun to partner with governments in the Global South in order to implement large-scale programmes, including health systems strengthening projects and policies associated with the Universal Health Coverage agenda (Hafner & Shiffman, 2013; Prince, 2016). These large-scale and national programmes differ significantly from the vertical disease programmes that global health organisations have tended to favour in the past few decades. Vertical disease programmes typically target single diseases – such as HIV/AIDS, malaria, or tuberculosis – and have often been implemented by global health organisations without much state oversight or coordination. Anthropologists and social scientists who have studied these programmes have therefore focused on the distinctive dynamics of sovereignty that are produced when global health organisations operate in spaces where the state is not 'the privileged locus of sovereignty' (Hansen & Stepputat, 2006, p. 309). In analysing the work of global health organisations, these scholars have developed a range of valuable concepts, including 'mobile sovereignty' (Pandolfi, 2008), 'therapeutic sovereignty' (Nguyen, 2010), and even 'scientific sovereignty' (Samsky, 2012).

As I aim to show in this article, however, large-scale and national-level global health programmes are creating slightly different dynamics of sovereignty and governance. First of all, these large-scale programmes involve significant state involvement and oversight because senior politicians and officials need to 'buy-in' to these programmes from the outset (Herrick & Brooks, 2018). Global health organisations therefore invest a lot of time in attracting the support of politicians and

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government officials – setting up social media campaigns, lobbying at global health conferences, and arranging face-to-face meetings.[1] As Clare Herrick (2018) has noted:

> The ultimate and most overlooked of all partners are Presidents and top-level bureaucrats at Ministries of Health, Education and Finance. These actors … are the only ones with the power to really strengthen health systems. Without state buy-in and action, changes remain limited to small-scale contexts: one hospital, one area of clinical practice etc.

Many global health organisations have recognised this and are increasingly seeking the support of high-level state actors. Furthermore, large-scale programmes require global health organisations to work with governments at different levels of the health system, rather than intervening in a single small-scale context. When global health organisations work on vertical disease programmes, they might be located within a particular district or province. By contrast, large-scale partnerships require global health organisations to engage with the public health system and government officials at multiple levels. Even if many global health organisations today seem to operate with 'a vision of a global, biological humanity' that has ultimately 'outgrown the older nation-state plan of humanity' (Rees, 2014, p. 466), they still have to work extensively with state actors if they wish to implement large-scale programmes.

The rise of large-scale programmes therefore raises a key question: what novel configurations of sovereignty are these large-scale global health partnerships producing today? This article addresses this question by examining and analysing a large-scale global health partnership in the southern African country of Zambia. This partnership brought together the Zambian government and several global health organisations, the most prominent of which was the Clinton Foundation. The aim of this partnership was to introduce a new cohort of 5000 community health workers (CHWs) throughout the country in order to strengthen the health system and move towards the goal of Universal Health Coverage (UHC). Adopting an 'ethnographic approach to sovereignty in practice' (Hansen & Stepputat, 2006, p. 297) and building on recent scholarship on global health and sovereignty, I show how officials from the Clinton Foundation came to believe that high-level government actors had informally entrusted them with the authority to implement the community health worker programme themselves. Officials from this global health organisation therefore felt that they could temporarily act as de facto state officials in order to implement the programme before eventually 'handing it back' to the government.

This partnership revealed a dynamic that I analyse as the 'outsourcing of sovereignty'. I develop the concept of outsourcing sovereignty by showing how Clinton Foundation officials came to feel that they could legitimately take on the responsibilities of government officials. As this article demonstrates, this outsourcing of sovereignty created problems at lower levels of the health system because provincial and district-level government officials in rural areas felt excluded from the programme and did not recognise it as a government programme. This article analyses this outsourcing of sovereignty in order to contribute to the broader task of understanding 'forms of governmental pluralism [that] are both increasingly prolific and emerging in novel ways' (Brown, 2015, p. 351) in global health today. In conclusion, I point to some of the troubling effects of this mode of outsourcing sovereignty. Although the partnership was intended to strengthen the health system and enable the government to coordinate the work of a new group of rural health workers, the actions of the Clinton Foundation ultimately undermined the capacity of the state and created greater fragmentation in rural healthcare provision.

Methods

This article is based on 6 months of fieldwork in Zambia conducted between 2019–2020. This research involved interviewing and spending time with government officials, employees and former employees of the Clinton Foundation, district government officials, and frontline health workers in rural areas. The research was multi-sited and involved interviews with officials in Zambia's capital

city, Lusaka, and fieldwork in a rural province, which also included interviews, group discussions, informal conversations, and participant observation at rural health posts. In the capital city, Lusaka, I interviewed officials from the government and global health organisations who were (at the time of the research) directly involved in the CHW programme. I also interviewed officials who had been previously involved in the programme. Most of the people who were no longer involved in the programme felt able to speak more freely about their experiences than those still directly involved with it. A quick turnaround of officials – both in the government and in global health organisations – meant that it was often difficult to locate particular people who knew about the programme and were involved in its development. This became easier as I met and interviewed more people, who were able to introduce me to others.

Although this article argues that high-level politicians and bureaucrats play a crucial role in large-scale global health partnerships, the fieldwork I conducted did not involve close ethnographic research with these politicians and bureaucrats. The difficulty of gaining ongoing access for undertaking this kind of research is perhaps one of the central reasons why more research is not conducted alongside these high-level political actors. However, the argument that I make here is that we need to consider the effects of the actions of these political actors – something that is visible at different levels of the health system. In rural areas, I conducted fieldwork and interviews with government officials and health workers, including those who had been enrolled on the CHW programme and who had been trained and deployed to a rural health post. I encountered challenges in this work because the CHW programme itself was not running as smoothly as it was initially hoped it might (some of the reasons for which I outline in what follows). Many trained CHWs had not yet been deployed and this meant that government officials were sometimes concerned that I would hear grievances and criticisms of the programme. 'Don't believe everything they [CHWs] tell you', I was often told by district government officials. I was also mindful of the fact that, as Moyi Okwaro and Geissler point out, 'inviting informants to discuss collaborative relations may threaten those relations' (Okwaro & Geissler, 2015, p. 496). However, unlike some ethnographies of global health partnerships, I was not encountering people who were working in close proximity to their partners (e.g. at a research institute or hospital) and many of my interlocutors were no longer directly involved in the task of sustaining the partnership. As the programme was implemented, employees of the Clinton Foundation conducted research on the programme to measure its success. I draw on some of this work in what follows as it provides rich material on the early phases of the programme as well as revealing how Clinton Foundation employees perceived their own role.[2]

Global health partnerships and sovereign responsibility

During the past twenty years, anthropologists and social scientists have analysed how the proliferation of NGOs and global health organisations has produced new forms of sovereignty. Anthropologists such as Mariella Pandolfi have shown how humanitarian organisations move through space, constructing zones within which they exercise new kinds of political authority and produce forms of 'migrant sovereignty' (2008). Other anthropologists have examined how global health organisations have been able to create spaces of biopolitical management on a small and limited scale, enacting what Peter Redfield (2005) calls a 'minimal biopolitics'. At the same time, scholars have explored how global health actors have enacted forms of 'scientific sovereignty', using their expertise to enable them to govern by creating political spaces in which knowledge about 'human biology' is used as a 'justification … [by] decision makers who have supplanted the state' (Samsky, 2012, p. 317). These dynamics of sovereignty have also affected the populations who encounter global health actors, creating new modes of claim-making and citizenship (Nguyen, 2010). Scholars of global health organisations and sovereignty have shown how new forms of 'citizenship' emerge as people make claims on non-state organisations on the basis of their illnesses and afflictions – creating 'therapeutic' and 'biological' forms of citizenship (Nguyen, 2010; Petryna, 2002, 2004). While these debates on sovereignty have offered crucial insights, some of this work

seems to take-for-granted the idea that global health organisations operate in contexts where the state is 'weak', lacks 'capacity', or has 'retreated'. Consequently, a number of anthropologists in recent years have started to question this assumption in order to examine ethnographically the role that so-called 'weak' states actually play in global health (e.g. Brown, 2015; Geissler, 2014; Geissler & Tousignant, 2016).

This has been particularly important for anthropologists who have studied global health partnerships. These scholars have described, analysed and critiqued the political and ethical dimensions of a wide variety of global health partnerships, including scientific research projects (Crane, 2010; Crane, 2013; Geissler & Tousignant, 2016; Moyi Okwaro and Geissler, 2018), vertical single-disease programmes (Brown, 2015; McKay, 2018), and the work of European and American health volunteers in clinics and hospitals (Wendland, 2016; Sullivan, 2016). These scholars have highlighted how the discourse of 'partnership' itself – with its connotations of equality, mutuality and collaboration – often disguises profound forms of inequality and friction (Brown and Prince, 2016; Kenworthy et al., 2018). But these scholars have also attended ethnographically to the working relationships between state officials and employees of global health organisations in order to move discussions away from 'misleading notions of "weak" or even "disappearing" . . . statehood' (Geissler, 2014, p. 2). Instead, this work has begun to explore how an 'expanding set of actors' are creating 'new forms of statehood and governance' (Brown, 2015, p. 342).

Among this recent work, one of the most influential arguments has been made by the anthropologist Hannah Brown (2015), who describes an American-funded HIV/AIDS programme in western Kenya. Brown notes that, although the Kenyan state clearly lacked resources in comparison to the wealthy global health organisations with whom it was partnered, this did not mean that the state simply 'retreated' while global health organisations came to exercise sovereignty. Instead, Brown points out that government officials and global health organisations all 'asserted the importance of the state, even when the state was unable to provide resources' (2015, p. 342). This was because the state remained the only actor who ultimately possessed the 'sovereign responsibility' to provide for Kenyan citizens. The concept of 'sovereign responsibility' enables Brown to highlight the continued centrality of the state as the actor who is responsible for its citizens, even if it does not possess the resources and capacities to provide services for those citizens. In Brown's analysis, global health partnerships therefore involve careful negotiation and a mutual recognition of the sovereign responsibility of the state. In Kenya, Brown observed that conflicts tended to emerge when government officials felt that their sovereign responsibility was being challenged.

In Zambia, I found the same emphasis on the sovereign responsibility of the state among officials from the government and the Clinton Foundation. But I found that this emphasis on the state's sovereign responsibility played out in a slightly different way. In this case, employees from the Clinton Foundation accepted that the government was the source of sovereign responsibility, but they felt that they had been given the authority to exercise a limited form of sovereignty by certain key actors within the central government. Clinton Foundation employees did not see themselves as challenging the sovereign responsibility of the state, but rather as an organisation that had taken on some of the responsibilities of the state for a limited period of time – they were temporarily an extension of the state. Clinton Foundation employees knew that the ultimate responsibility for the community health worker programme lay with the state, but they felt their role in the partnership gave them the authority to exercise a limited form of sovereignty on behalf of the state. Indeed, the temporal dimensions of this sovereignty were central to the 'exit strategy' of the Clinton Foundation. These officials knew that they could not be an extension of the state indefinitely – this would have been both politically illegitimate and financially 'unsustainable' in the language of Clinton Foundation officials. Clinton Foundation officials therefore understood their actions in relation to an imagined future handover point when the government would be solely responsible for the programme (cf. McKay, 2018).

It is important to note that this dynamic of outsourcing of sovereignty is visible when we consider that 'the state' itself includes a diverse range of actors – from high-level bureaucrats in

the capital city to low-level district medical officials in remote rural provinces. When we consider the 'expanding set of actors' (Brown, 2015, p. 342) who are involved in global health partnerships, it is important to appreciate that state actors are themselves a highly differentiated group. In the sections that follow, I demonstrate ethnographically how this outsourcing of sovereignty emerged in practice.

Zambia's community health worker programme

In recent years, a number of global health organisations have argued that African countries should introduce large-scale community health worker (CHW) programmes in order to address the global health workforce crisis. Advocates point out that there are currently millions of volunteer CHWs whose work is not consistently remunerated and whose activities are not coherently integrated within public health systems. These volunteers could be formally recruited and integrated into health systems as a cost-effective way of improving health coverage in many African countries, especially in remote and rural areas. Prominent advocates of large-scale CHW programmes include the World Health Organisation (WHO), the United States Agency for International Development (USAID), and the Global Health Workforce Alliance (GHWA). There have been high-profile global health campaign groups such as One Million Community Health Workers, an organisation that aims to 'accelerate the attainment of universal health coverage in rural sub-Saharan Africa' by helping governments to 'scale-up nationally recognised CHW programmes'.[3]

In 2011, a new large-scale CHW programme of this kind was implemented in Zambia with the aim of training 5000 CHWs by the year 2020.[4] The ambition was that these CHWs would be deployed to rural health posts in every district in the country where they would screen patients and treat common illnesses (e.g. malaria, diarrhoea, respiratory tract infections, burns or sores), help women to deliver in emergencies, and engage in 'health promotion' activities (e.g. encouraging the use of mosquito nets, advising on water and sanitation issues, and offering guidance on minor illnesses and afflictions). In more complicated cases, they would be able to refer patients to the nearest clinic or hospital (see Government of Zambia, 2010). A number of outside organisations were involved in the development of this CHW policy, including USAID, UNICEF, and DfID. These organisations helped to fund a 'situational analysis' and offered 'technical advice' to the Ministry of Health and other government departments (see Zulu et al., 2013). The partner that played the most prominent role was the Clinton Foundation.[5]

During interviews with Zambian bureaucrats and officials from many of the global health organisations who were involved, I was told repeatedly that the early high-level 'buy-in' of senior politicians had been crucial. Thomas, a Zambian man in his mid-thirties who was employed by the Clinton Foundation during the early stages of the partnership, told me that 'this particular scheme had serious champions in the Ministry of Health'. He continued,

> People who had seen the rural need . . . got behind the scheme. At the highest level there [was] buy-in, and the president and PS [Permanent Secretary at the Ministry of Health] were very keen on the programme . . . there was always buy-in from the beginning.

In a policy analysis paper whose authors include several Clinton Foundation employees, it is reported that the director of one of the global health organisations involved used to phone the Minister of Health personally to encourage the government to speed up the implementation of the programme (Zulu et al., 2013, p. 8).

After receiving high-level support from senior government figures, Clinton Foundation employees felt that they had acquired political authority and legitimacy from key actors within the central government – and this is central to understanding how sovereignty was 'outsourced' in practice. This can be seen more clearly by considering the perspective of some of the officials who worked for the Clinton Foundation at the time.

Holding the government's hand

In the literature produced by the Clinton Foundation, the CHW programme is described as a government programme being delivered in 'partnership' with the Clinton Foundation, whose role is to provide 'technical advice' (Clinton Foundation, 2013). But this presents the Clinton Foundation as the junior partner and therefore obscures the inequality of the partnership. Visitors to the Clinton Foundation offices who have been to the Ministry of Health will notice some obvious differences: in contrast to the slightly run-down 1960s building that houses the Ministry of Health, the Clinton Foundation offices are situated within an attractive compound surrounded by tall trees in an affluent area of the city. Inside, the rooms are neatly decorated and freshly painted. When I first visited the offices, I was invited to wait in a large air-conditioned conference room, equipped with video conferencing technology.

But the inequality between the Clinton Foundation and the Ministry of Health was not only visible in these material terms. When I visited in August 2019 to meet with Katie, a Zambian woman who had been employed by the Clinton Foundation for several years, I was surprised to discover that her central job was to work on the CHW programme. By contrast, the officials I had met at the Ministry of Health tended to work on the programme when they could find the time among other commitments. Several government officials complained that they had many other jobs to do and could not devote as much time to the CHW programme as they would have liked. A retired former Zambian government official called Sarah said,

> One of the problems was that the Ministry of Health did not have the same number of staff as the Clinton Foundation looking at the [CHW] scheme. So, the Ministry of Health people are looking at the scheme once in a while when they have the time, but the Clinton Foundation has somebody working on the scheme the whole time.

When employees (and former employees) of the Clinton Foundation discussed this inequality, they acknowledged the lack of government resources, but in terms that legitimised their own position. When I asked Katie about the relationship between the Clinton Foundation and the government, she explained that the Clinton Foundation had overseen the programme continuously from its inception to the present day. Katie insisted that the Clinton Foundation was therefore the only organisation that possessed the 'institutional memory' to recall the original idea and ambition for the programme. Katie described how bureaucrats and politicians within the Zambian government did not have the same resources or time as employees of the Clinton Foundation to devote to the programme – many of these government officials lost enthusiasm, were diverted by other tasks, or were simply moved to other government departments. In Katie's view, this meant that it was the responsibility of the Clinton Foundation to remember that the programme initially had high-level support from the government, even if the particular Zambian politicians and bureaucrats who oversaw the original partnership were no longer present: 'Our approach to the programme is that we are the holders of institutional memory at times'. Katie described a period of time when one of the key government officials working on the programme was unwell and 'so we were the *only* holders of institutional memory of the scheme'. The idea of 'institutional memory' gave actors from the Clinton Foundation a kind of political legitimacy. The Clinton Foundation had a responsibility to 'remember' the original desires of the key actors within the government and to act on their behalf when they were no longer present in the Ministry of Health. It is not surprising that in the same discussion Katie told me that 'it almost feels that we are an extension of the Ministry of Health in some ways'.

Despite this, it was crucial to Katie – and to many other employees – that the programme would eventually be 'handed over' entirely to the government. As I mentioned above, these officials repeatedly emphasised the 'sovereign responsibility' of the state. The period of time from the inception of the programme to the present was a transitional phase in which the Clinton Foundation had to 'hold the government's hand', in Katie's words.

The idea that the Clinton Foundation could remember the original enthusiasm of high-level government officials for the programme – and had a responsibility to nurture this 'institutional

memory' – was entirely compatible with the idea that the ultimate responsibility for the programme belonged to the government. Clinton Foundation employees who worked on the programme felt that a certain kind of political authority had been transferred to them by key actors within the Ministry of Health, but this authority was not indefinite and it was granted in order to achieve a specific task: namely, to implement the CHW programme in rural areas of the country.

The 'outsourcing of sovereignty' here was not a formal arrangement – rather, it describes an informal settlement that emerged between government officials and Clinton Foundation employees. In interviews, it often seemed to me that high-level Zambian government officials were prepared to accept that the Clinton Foundation would act independently at times – although some officials told me that they believed the Clinton Foundation overstepped the boundary too often. The legitimacy that Clinton Foundation officials felt they possessed as the holders of political authority and 'institutional memory' emboldened them to act independently of formal government structures – and this enabled sovereignty to be 'outsourced' to the Clinton Foundation in practice. As I show in the next section, the consequences of this outsourcing of sovereignty were particularly striking at lower-levels of the health system. For government officials outside of Lusaka, the CHW programme did not appear to be a government programme that was being delivered in 'partnership' with the Clinton Foundation. Rather, these officials tended to regard the CHW programme as simply a Clinton Foundation programme.

The 'partnership' in rural Zambia

On a long journey in 2019, on my way to the rural district where I was conducting fieldwork, I stopped briefly at a number of provincial and district medical offices to introduce myself and inquire about the CHW programme. During these encounters, I was struck by how often government officials responded to my inquiries about the programme by saying, 'Yes, that's the Clinton Foundation programme'. To many Zambian officials and health workers in rural areas, the programme appeared to be entirely led by the Clinton Foundation.

There were a number of reasons for this and they were not always the result of the actions of Clinton Foundation employees. For example, when the first newly-trained CHWs were first deployed in rural districts they were sent with new equipment. But unlike the visibly branded equipment that is ubiquitous in district medical offices and rural health clinics in Zambia (from computers with USAID stickers to World Vision T-shirts) these new CHWs were sent with items that were stamped with the Zambian Ministry of Health logo. This was a way of emphasising that these new health workers were government employees who were part of a new government programme. Despite this effort, many local officials and health workers immediately identified the new CHWs as people who must have been funded by an outside organisation. An official called Simon recalled the period of time when the first CHWs were deployed:

> Simon: "When they [the community health workers] left the training schools they would have gum boots, an umbrella and a bicycle and other things and so people knew it was outside money."
>
> Me: "But the gum boots and umbrellas and things, they didn't have the [Clinton Foundation] logo or anything on them?"
>
> Simon: "No, they said Ministry of Health on them, but people still knew that, 'Ah, this looks like outside money! The Ministry doesn't have the money for these things'."

The conspicuous presence of new equipment led people to identify CHWs as 'outsiders'. It was difficult for people to recognise the CHW programme as a state-led project due the material wealth that the scheme seemed to have attracted – whether or not items were labelled 'Ministry of Health'.

But the actions of Clinton Foundation employees added to the perception in many rural areas that the programme was run by the Clinton Foundation. At the district-level, outside partner organisations were expected to deliver programmes through the district medical office, so that

government officials knew who was entering the area and what work they were doing. A government official told me that 'we have guidelines to help partners . . . They are cleared through the ministry and then they go to the province and then to the district for them to start implementing'. But in the case of the CHW programme, Clinton Foundation officials often decided to 'bypass' this channel. This became problematic when certain items were delivered to CHWs directly by officials from the Clinton Foundation. Bicycles, in particular, were a regular source of contention. As a government official called Miyanda told me:

> That was something that [the Clinton Foundation] did, but it is not acceptable for us. This causes problems, especially when the [CHWs] were given bicycles – and at the end of the day they belong to the Ministry, so this is why these items need to pass through the district so that they are recorded as property of the Ministry and this is the responsibility of the district to ensure that the bicycles are looked after.

At the same time, employees at the Clinton Foundation would often bypass district medical offices in order to 'speed up' the implementation of the programme. Simon explained to me that Clinton Foundation employees often did this in order to deliver items to newly deployed CHWs:

> The first 2 years we had the funding to repair bicycles and other supplies for the [Community Health Workers], so, because of that, sometimes [The Clinton Foundation] would drop off a bicycle . . . when they were in the district. So, this was one of the reasons why people would always think that the [CHWs] were volunteers from [the Clinton Foundation] . . . This made some people . . . [at the district level] say "well, you aren't really one of us".

District medical officials spoke about this as a widespread problem that they often encountered when working with outside partners (cf. Brown, 2015, p. 340). Partners often became impatient and wished to save time or avoid the bureaucratic entanglements of including the district medical office in their activities. But in the case of the CHW programme, this behaviour was not only driven by an attempt to avoid bureaucratic entanglements but can be understood in relation to the feeling among Clinton Foundation employees that they had the political authority and high-level backing to implement the programme themselves.

This dynamic extended to the supervision of newly qualified community health workers. When the CHW programme was first implemented, Clinton Foundation employees were involved in evaluating and monitoring the success of the programme. But these evaluations were also used by Clinton Foundation employees to oversee the work of CHWs and govern their conduct. I was told by CHWs at a rural health post that they were sometimes visited by Clinton Foundation employees during the early days of the programme. Unsurprisingly, many of these CHWs came to feel that they were directly accountable to the Clinton Foundation (see also Zulu et al., 2015). Several CHWs explained to me that when they signed their employment contracts, they had been led to believe that they were simultaneously accountable both to the Clinton Foundation and to the Zambian government. The lines between 'project evaluation' and formal management of the work of CHWs were blurred in these encounters because Clinton Foundation employees acted as de facto government officials, supervising this new cohort of government employees and holding them to account for their professional conduct.

Ironically, this form of outsourced sovereignty ultimately created a situation that became frustrating for Clinton Foundation employees. In the rural province where I spent time, Clinton Foundation officials had to persuade district medical officials to take 'ownership' of the scheme – indeed, Clinton Foundation employees had to persuade many of the same officials (whose offices they had been avoiding) that the CHW programme had been a government programme all along. As a former Clinton Foundation put it:

> We had it that when we were visiting the district, people [i.e. government officials] would be saying to us, 'Your people [the CHWs], they have failed to do this and that' and we would say, 'Don't call them our people! They are not our people, they are *your* people'.

One Clinton Foundation employee told me that they were developing a new workshop for district government officials to attend in order to train them about the programme. This workshop would explain that CHWs were government health workers and needed to be supervised within the formal

structures of the government health system. Having implemented the programme without including government officials, Clinton Foundation employees then had to find a way to encourage these officials to take responsibility for the programme. This reveals clearly how the dynamic of outsourcing sovereignty creates enduring problems at lower levels of the health system.

Conclusion

In this article, I have tried to show how an informal dynamic of 'outsourcing sovereignty' emerged in this large-scale global health partnership in Zambia. This dynamic may be more common in global health partnerships than anthropologists and social scientists have recognised. A lot of scholarship on global health partnerships has focused on how these partnerships are enacted and negotiated in particular bounded ethnographic settings: the research institute, the clinic, or the government district. In these settings, when global health organisations partner with 'the government' or 'the state', the latter can often be identified ethnographically as a relatively coherent entity or group of actors. By contrast, in this article I have tried to show that the 'state' itself as a 'partner' includes a diverse array of actors, from the central government to rural districts. For many officials from the Clinton Foundation, certain key state actors were the important partners who authorised their work, while lower-level government officials could be overlooked.

This analysis shows why this dynamic of informal outsourcing is politically undesirable. Formal government 'outsourcing' has long been considered to be a troubling phenomenon among many critical scholars of global health because it is associated with the rise of neoliberal economics and the privatisation of public services (Harvey, 2007; Hansen & Stepputat, 2006, p. 308). The rise of global health organisations such as the Clinton Foundation is a part of this broader history, but in this case the 'outsourcing' I describe was troubling precisely because it was enacted by officials who were supposed to be committed to strengthening the state. Officials from the government and the Clinton Foundation identified the programme as a way of strengthening the public health system and enabling the government to coordinate healthcare in rural Zambia more effectively. Despite this, the actions of the Clinton Foundation ultimately undermined the capacity of the state to coordinate healthcare delivery and created greater fragmentation.

Critics of vertical disease programmes have often argued that they have 'drained resources and expertise away from national health systems' (Prince, 2016, p. 164). And although some global health organisations seem to recognise this as a problem, they continue to reinforce this dynamic (cf. Storeng, 2014). It therefore remains a crucial task for critical scholars to examine how new forms of sovereignty are impacting health systems and health workers in countries where global health organisations continue to exercise considerable political power.

Notes

1. One recent example is the 'Dear Minister' campaign by the Kenyan organisation AMREF, which aims to appeal directly and personally to ministers of health in African countries. See https://amref.org/dearminister/ (Accessed 10 February 2021).
2. Ethical clearance for the research was given by the University of Zambia, the Ministry of Health, the National Health Research Authority (NHRA) of Zambia, and from the provincial and district medical officers in the areas where I conducted research. Informed consent was given for all interviews and the identities of all participants have been anonymised.
3. See http://1millionhealthworkers.org/ (accessed 12 October 2018).
4. At the time of writing, the number remains under 3,000. These CHWs were named Community Health Assistants (CHAs) in order to differentiate them from other CHWs. For a fascinating and detailed account of the development of this CHW policy, see Zulu et al. (2013).
5. Throughout this article, I am referring to the Clinton Health Access Initiative (CHAI), but I call this organisation the Clinton Foundation for the sake of brevity. In 2010, the Clinton Foundation's HIV/AIDS Initiative became the Clinton Health Access Initiative (CHAI).

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