Chapter 4
Building Health-Oriented Organization Partnerships

ABSTRACT

This chapter examines the strategic formation of partnerships among health-oriented organizations—including ministries of health, NGOs, academic institutions, and multilateral agencies—to advance interoperable EHR systems. It highlights successful models of collaboration in resource-constrained settings and identifies key enablers such as trust, shared governance, and capacity-building. The chapter also critiques partnership failures rooted in power asymmetries and misaligned incentives, offering recommendations for equitable and sustainable engagement.

INTRODUCTION

As discussed in Chapter 1, the Ebola epidemic of 2014 that eventually resulted in America's first travel-associated case of the infection in Dallas, TX (Molinari et al., 2018; Sevilla, 2017); and the Covid-19 pandemic, that reached Seattle, WA, underscores that local public health systems, particularly in large international cities such as Dallas and Seattle, are vulnerable to foreign contagions, and that the term Global Burden of Disease (GBD) is not a casual term or misnomer, and is truly global regardless of the infections' point of origin and local public health systems must have contingencies for public health emergencies of international concern (PHEIC), such as outbreaks of unknown or nonindigenous diseases threaten global health (Turnock et al., 2022).

Five years post-Ebola, the Coronavirus disease pandemic of 2019 also revealed that zoonotic diseases at the local or public health level can, and often cross interna-

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tional borders, creating examples of the importance of local outbreak preparedness for global health emergencies (Carter et al., 2024). Increases in global trade, travel, and immigration fueled by globalization expose local public health systems to global threats. Globalization allows access to foreign markets to provide goods and services to non-local societies (McCloskey, 2023). The current global population is 8.4 billion people. The population is projected to reach 9.8 billion by the year 2050 and, by the year 2100, 11 billion (Mishra et al., 2024). The global population will increase by 30 per cent over the next 76 years, increasing the need for goods and services, travel, and immigration. Globalization is growing, not declining, as economies in LMICs expand with the help of economic and multinational trade agreements, globalization is here to stay (Lincicome, 2023).

The global community comprises 8.4 billion people across an international family of 195 countries, 193 of which are recognized by the United Nations. The complexities of maintaining order by ending or preventing wars, addressing global problems such as climate change, and alleviating poverty in low-to-middle-income countries (LMIC) are, without question, high priorities, and international leaders must collaborate to overcome these traditional security concerns. However, while powerful and influential global leaders work vigilantly to solve conventional problems such as the war between Russia and Ukraine or the conflicts between Israel, Iran, and Hezbollah, a more significant security threat lurks among populations without regard to land ownership or religious affiliations. It is a threat to Muslims and Jews. The threat has no bias for or against military alliances such as NATO. The danger is fair and impartial, whether its prey is from the developed West or the developing Global South. The threat does not differentiate nor display any preference to G20 nations over the BRICS nations. It is an equal opportunity killer. It is resilient, resourceful, resistant, and resolute. The threat is one billionth our size and has taken more lives than all the world's wars combined. The danger is the disease, the most critical non-traditional threat to health security (Heymann & Rodier, 2004).

Globalization increases trade, logistics coordination, and immigration, and travel to large international cities, such as Seattle, WA and Dallas, TX. However, there is a gap in data-sharing between national and international health-oriented organizations with local public health systems in large cities such as Dallas and Seattle (Carter et al., 2024). Heyman and Rodier (2004) suggested that health security is the responsibility of local, national, and global leaders. The COVID-19 and Ebola pandemics began as public health emergencies; however, when there is a gap in data-sharing between national and international health-oriented organizations with local public health systems, airports, logistics systems in large international cities, outbreak preparedness for international contingencies suffers, the contagion will proliferate across international borders. Local or national public health emergencies become public health emergencies of international concern (PHEIC) (Carter